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SUBSTANCE USE HELPERS: AN EXPLORATION INTO THE RELATIONSHIP BETWEEN
PROFESSIONAL QUALITY OF LIFE AND POSTTRAUMATIC GROWTH

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for

The degree of Doctor of Philosophy

By

Denise Haggerty

May 2019

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Denise Haggerty

2019

**DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION
Department of Counseling, Psychology and Special Education**

Dissertation

Submitted in Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy (Ph.D.)

Executive Counselor Education and Supervision Program

Presented by:

Denise Haggerty, M.A., Community Counseling (Slippery Rock University)
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**SUBSTANCE USE HELPERS: AN EXPLORATION INTO
THE RELATIONSHIP BETWEEN PROFESSIONAL QUALITY OF LIFE AND POST-
TRAUMATIC GROWTH**

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ABSTRACT

SUBSTANCE USE HELPERS: AN EXPLORATION INTO THE RELATIONSHIP BETWEEN PROFESSIONAL QUALITY OF LIFE AND POSTTRAUMATIC GROWTH

By

Denise Haggerty

January 2019

Dissertation Supervised by Debra Hyatt-Burkhart

There has been limited research on the potential for substance use helpers to have positive experiences as a result of their therapeutic work, previous research on the field of substance use treatment and the impact of working with individuals whom struggle with substance use disorders has been explored. The purpose of this study was to determine if a relationship exists between substance use helpers' professional quality of life (compassion satisfaction, secondary traumatic stress, and burnout) with posttraumatic growth. In addition, this study also sought to determine if a relationship exists between personal and professional characteristics of substance use helpers and posttraumatic growth. Suggestions for future research include exploration of specific personal and environmental characteristics such as length of employment, location (rural vs urban), level of care (residential vs outpatient), and how these may contribute to experiences of posttraumatic growth. Additionally, comparisons of

substance use helping professionals' experiences of posttraumatic growth with other helping populations could provide further insights into contributing factors to positive outcomes in vicarious experiences.

DEDICATION

This dissertation is dedicated to Catherine Greer who taught me to never stop following the music in my heart.

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CHAPTER 1

Introduction

The use of mind-altering substances dates back to the earliest documentation of human experiences. In addition to a lengthy history of substance use there has also been a protracted history of individuals who sought to battle against the deleterious effects of addiction that can result from the use of substances (Robinson & Adinoff, 2016; White, 1998). Treatment for drug and alcohol addiction in the United States, spans the mid 1700's when Native American tribes developed sobriety "Circles" in an attempt to treat alcohol abuse, to the mid 1900s and the beginnings of Alcoholics Anonymous (White, 1998). Now in the 21st century treatment options for individuals who are affected by substance use disorders are faced with a multitude of options in their search for help, which vary in approach, intensity, and type of treatment providers (White, 1998).

Today treatment facilities that focus on individuals affected by substance use disorders operate from a variety of differing perspectives and approaches, some of which include 12 step abstinence based, religious abstinence based, trauma-informed, medication assisted treatment, combinations of perspectives, as well as providers utilizing multiple different theoretical approaches to treating substance use disorders (Robinson & Adinoff, 2016; White, 1998). Extensive research has been done to investigate the unique challenges and effects of substance use disorders which professional helpers in the field must take into account and consideration in their attempts to engage with their clients and provide services (Bergman, Kelly, Nargiso, & McKowen, 2016; Dennis, Scott, Funk, & Foss, 2005; Ericson, 2001; Legha, Raleigh-Cohn, Fickenscher, & Novins, 2014; Perkins & Sprang, 2013; Pullen & Oser, 2014; Scott & Patterson, 2003). The previous research has provided drug and alcohol helping professionals with insight

into the unique obstacles that this population of helpers must face as well as new insights and approaches in the treatment of substance use disorders. In addition to the challenges that substance use helpers face research has also shown connections between substance use disorder and traumatic life events (Brown, 1994; Najavits & Hien, 2013).

For years research has explored the negative effects of traumatic exposure and the impact it has on individuals, a simple PsychInfo search for “trauma” results in 50,404 academic journal articles on the topic. In addition to the extensive exploration of the impact of exposure to traumatic events on individuals, the relationship between traumatic life events and substance use disorders has been investigated and has shed light on the connections between trauma and substance use disorders (Baschnagel, Coffey, & Rash, 2006; Brown, 1994; Bryan, Norris, Abdallah, Stappenbeck, Morrison, Davis, George, Danube, & Zawacki, 2016; Cohen & Densen, 1982; Dansky & Bradley, 1996; Najavits & Hien, 2013; Roberts, Roberts, Jones, & Bisson, 2015). Much of the research has largely focused on, and been conducted on, the substance users who have also been exposed to traumatic events. This has led to the development of trauma-informed models of treatment (Najavits & Hien, 2013) as well as to a recognition of the lack of training and preparedness of drug and alcohol helpers in addressing the relationship between trauma and substance use disorders (Bride, Hatcher, & Humble, 2009). Although research has investigated the challenges and unique experiences of drug and alcohol helpers may face as helping professionals as well as the correlation between substance use disorder and trauma. There has been far less attention in the professional body of research which has been focused on the impact on drug and alcohol helping professionals themselves, who engage in empathic therapeutic relationships with individuals in substance use disorders treatment. That is to say that within the

professional body of literature little attention has been paid to how working with this population of clients impacts professional helpers.

The existing body of research on the impact of empathic therapeutic engagement for drug and alcohol helpers has largely focused on the negative consequences of working with individuals who are affected by substance use disorders. Research has recognized that engaging in therapeutic work with trauma victims, as well as with substance use disordered clients does negatively affect professionals in the helping field (Bride & Kintzle, 2011; Elman & Dowd, 1997; Fahy, 2007; Figley, 2002; Maslach, 1982; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Young, 2015). Researchers agree that helping professionals who participate in therapeutic relationships with traumatically exposed individuals, may struggle with psychological distress and experience symptoms of vicarious trauma, secondary traumatic stress, burnout, and compassion fatigue, as a result of vicarious exposure to their clients suffering (Canfield, 2005).

In addition to the large body of literature that has investigated the negative effects of helping on professional helpers, a growing body of literature has begun to investigate potential for positive experiences as a result of working with traumatized clients. Investigations into the potential for vicarious resilience (Engstrom, Hernandez, & Gangsei, 2008), compassion satisfaction (Stamm, 2010), and vicarious posttraumatic growth (Arnold, Calhoun, Tedeschi, 2005; Hyatt-Burkhart, 2014), have all begun to gain momentum and attention in the professional literature. Despite this shift, investigations into drug and alcohol helpers positive experiences as a result of their work continue to be lacking. A comprehensive review of the relevant literature revealed only one research article that discusses the potential for drug and alcohol helpers to have positive experiences as a result of their therapeutic work (Cosden, Sanford, Koch, &

Lepore, 2016). Cosden et. al. (2016) explored treatment providers who provided services to adults seeking help for substance use disorders experiences of both vicarious trauma and vicarious posttraumatic growth and found significant positive associations between vicarious trauma and vicarious posttraumatic growth however it should be noted that multiple limitations appeared in the study including a small sample size (N=51). No other articles were discovered that examined substance use disorders helpers and vicarious posttraumatic growth.

Although there is very limited research on the potential for substance use helpers to have positive experiences as a result of their therapeutic work, previous research on the field of substance use treatment and the impact of working with individuals whom struggle with substance use disorders has been explored. The primary focus of this previous research on substance use helpers being impacted by their work has largely been focused on pathology and a unipolar treatment modality (Bride & Kintzle, 2011; Fahy, 2007; Perkins & Sprang, 2013; Roche, Duraisingam, Trifonoff, Battams, Freeman, Tovell, & Bates, 2013; Smith, Whitaker, & Weismiller, 2006; Young, 2015).

The need for substance use helpers continues to grow, according the Substance Abuse and Mental Health Services Administration report to congress the shortage of drug and alcohol counselors has reached a crisis level (Hyde, 2013). The lack of attention of the positive experiences of drug and alcohol helpers may be a contributing factor in the shortage in the existing population. This quantitative study seeks to explore the relationship between professional quality of life (compassion satisfaction, secondary traumatic stress, and burnout) as it relates to experiences of posttraumatic growth among drug and alcohol helpers. The study seeks to provide empirical evidence of how professional quality of life (compassion satisfaction,

secondary traumatic stress, and burnout) relate to posttraumatic growth among drug and alcohol helpers and to fill the gap in the current body of literature.

Statement of the Problem

As stated above, investigations into the work of treating individuals who have had exposure to trauma and stressful life events has primarily taken a pathologizing approach (Amir, Stafford, Freshman, & Foa, 1998; Hyatt-Burkart, 2014). The pathology of the impact of working with individuals who have experienced trauma and stressful life events is evident in the academic journals as a simple PsychInfo search showed results for negative implications for helping professional, vicarious trauma n= 454, secondary traumatic stress n= 620, burnout n= 11,813, compassion fatigue n= 787, far outweigh positive implications for helping professionals such as compassion satisfaction n= 359, and vicarious posttraumatic growth n= 38. Similar searches in other data bases showed similar results. ProQuest search results indicated vicarious trauma n= 231, secondary traumatic stress n= 736, burnout n= 3,176 compared to compassion satisfaction n= 181, and vicarious posttraumatic growth n= 25. Google Scholar search results showed vicarious trauma n= 33,800, secondary traumatic stress n= 1,210,00, burnout n= 659,00 compared to compassion satisfaction n= 261,000 and vicarious posttraumatic growth n= 11,100. This creates a framework that eludes to the negative consequences for individuals who provide treatment to people who have experienced trauma or stressful life events and has implications for training, education, and supervision approaches.

With an increase in the research on the co-occurrence of trauma and substance use disorder, the pathological approach to research had bled over into the work that drug and alcohol helpers are expected to provide (Najavits & Hien, 2013). The research on drug and alcohol helpers mirrors that of trauma workers in that it has largely been dominated with a focus on the

negative impact of the work on drug and alcohol helpers. In fact within the professional literature, drug and alcohol helpers are consistently classified as being at a higher risk for experiencing burnout (Baldwin-White, 2016; Oser, Biebal, Pullen, & Harp, 2013) as well as exhibiting high turnover rates (Eby, Burk, & Maher, 2010; Young, 2015). Further exploration of the current state of research on drug and alcohol helpers follows this negative viewpoint with foci on vicarious trauma (Fahy, 2007), compassion fatigue (Fahy, 2007; Perkins, 2013), and secondary traumatic stress (Bride & Kintzle, 2011; Bride, Hatcher, & Humble, 2009; Ewer, Teesson, Sannibale, Roche, & Mills, 2015). In terms of the possible benefits or positive impact of treatment work with traumatized individuals who have substance use disorders on drug and alcohol helpers, to the best of this researcher's knowledge there is only one academic journal article which alludes to the positive impact on drug and alcohol helping professionals (Cosden, Sanford, Koch, & Lepore, 2016).

There is a large gap in the professional literature, especially in investigating potential benefits and positive experiences of drug and alcohol helpers. Although investigations into the positive experiences of helping professionals has begun to gain momentum and has as well as begun to show benefits of professional helpers vicarious experiences of growth in relation to other populations of helping professionals (Abel, Walker, Samios, & Morozow, 2014; Arnold et. al., 2005; Barrington & Shakespeare-Finch, 2013; Brockhouse, Msetfi, Cohen, & Joseph, 2011; Cohen & Collins, 2013; Hyatt-Burkhart, 2014), little has been done to investigate this phenomenon within the drug and alcohol population of professional helpers. Additionally, the need for drug and alcohol helpers continues to grow and continues to show higher turnover rates than other populations of helping professionals (Young, 2015). Previous literature on vicarious growth within other populations of professional helpers has largely taken a qualitative approach

to highlighting this phenomenon however few articles have provided any empirical evidence in describing these phenomena. Due to the unique challenges that drug and alcohol helpers face, there is a need to increase research into potential benefits and positive experiences of working within this population of helpers.

In order to add to the insubstantial body of research that examines drug and alcohol helpers professional experiences, this study sought to provide empirical data as well as illuminate drug and alcohol helpers positive experiences and potential benefits, and the relationship between professional quality of life (compassion satisfaction, secondary traumatic stress, and burnout) with posttraumatic growth among drug and alcohol helpers.

Purpose of the Study

The purpose of this study is to examine the potential for drug and alcohol helpers' positive experiences as a result of the work they do and to explore the possible relationship between their professional quality of life (compassion satisfaction, secondary traumatic stress, and burnout) and posttraumatic growth. In addition, this study seeks to explore potential relationships between drug and alcohol helpers personal characteristics and posttraumatic growth. This exploratory study seeks to determine if a relationship exists between professional quality of life, as measured by the Professional Quality of Life Scale V (ProQol V) (Stamm, 2010), and posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996), among drug and alcohol helpers working with adults in drug and alcohol treatment centers. The study will also explore if drug and alcohol helper's demographics information such as age, gender, relationship status, religious/spiritual status, education, years of experience, and level of care provided relates to professional quality of life and posttraumatic growth. Previous research on drug and alcohol helpers has primarily been focused on the

deleterious effects of working with this population, this study seeks to fill the gap in the professional literature and add to the understanding of the impact of therapeutic work on the drug and alcohol helper population.

Recent research has begun to explore how working with difficult populations can have a positive impact on helpers and the term vicarious posttraumatic growth has been coined (Arnold et. al., 2005). Although the focus on vicarious positive experiences that helpers may have as a result of their work with clients has been growing in the professional literature, the majority of the research has been qualitative, and little has been done to quantify these experiences. In addition to lack of quantifiable data on these experiences, there has only been one article to this researcher's knowledge, which focuses on drug and alcohol helper's experiences of vicarious growth. This study seeks to not only quantify positive experiences of helpers but also to address the lack of research on drug and alcohol helper's experiences of posttraumatic growth in relation to their professional quality of life.

Research Questions

The main questions to be addressed to be tested in this investigation are as follows:

1. How do drug and alcohol helpers personal characteristics (e.g. educational level, years of experience, recovery status, etc) relate to experiences of posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996)?
2. How does drug and alcohol helpers compassion satisfaction, as measured by the Compassion Satisfaction subscale of the Professional Quality of Life Scale V (ProQOL V) (Stamm, 2010), relate to experiences of posttraumatic growth, as

- measured by the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996)?
3. How does drug and alcohol helpers secondary traumatic stress, as measured by the Secondary Traumatic Stress subscale of the ProQOL V (Stamm, 2010), relate to experiences of posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996)?
 4. How does drug and alcohol helpers experiences of burnout, as measured by the Burnout subscale of the ProQOL V (Stamm, 2010), relate to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996)?

To address each of the research questions the following null and alternative hypothesis have been developed:

H₀1: Drug and alcohol helpers personal and/or professional characteristics (e.g. educational level, years of experience, recovery status) does not relate to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996).

H_a1: Drug and alcohol helpers personal and/or professional characteristics (e.g. educational level, years of experience, recovery status) does relate to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996).

H₀2: Drug and alcohol helpers compassion satisfaction, as measured by the compassion satisfaction subscale of the ProQOL V (Stamm, 2010) does not relate to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 2010).

H_a2: Drug and alcohol helpers compassion satisfaction, as measured by the compassion satisfaction subscale of the ProQOL V (Stamm, 2010) relates to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996).

H₀3: Drug and alcohol helpers secondary traumatic stress, as measured the secondary traumatic stress subscale of the ProQOL V (Stamm, 2010) does not relate to posttraumatic growth, as measured by PTGI (Tedeschi & Calhoun, 1996).

H_a3: Drug and alcohol helpers secondary traumatic stress, as measured by the secondary traumatic stress subscale of the ProQOL V (Stamm, 2010) relates to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996).

H₀4: Drug and alcohol helpers burnout, as measured by the burnout subscale of the ProQOL V (Stamm, 2010) does not relate to posttraumatic growth, as measured by PTGI (Tedeschi & Calhoun, 1996).

H_a4: Drug and alcohol helpers burnout, as measured by the burnout subscale of the ProQOL V (Stamm, 2010) relates to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996).

Significance of the Study

The subject of vicarious growth in helping professionals has received limited attention in the research. Most of the research that has been conducted has been qualitative in nature and has lacked a focus on those who function as drug and alcohol helpers. In order to increase the understanding of the experience of those who work as drug and alcohol helpers, it is important to consider the potential positive experiences of the work that they do. As it has been highlighted with other helping populations that positive experiences can allow helping professionals to dramatically change their vicarious trauma into experiences of deeper levels of admiration for the resiliency of their clients, experience higher levels of ability to cope with difficulties, and maintaining their sense of overall well-being (Saakvitne & Pearlman, 1996). Investigations into professional helpers experiences of vicarious posttraumatic growth has significant implications

for the overall helping profession as well as for drug and alcohol helpers. This study can provide implications for enhanced training, supervision, retention, and overall well-being of drug and alcohol helpers. This could reduce emotional and physical damage to workers, increase retention and reduce costs to society at large, as well as increase skill level of workers in the field of drug and alcohol helpers.

The Study

The experience of posttraumatic growth among drug and alcohol helpers has not gained attention in the professional literature, which has largely focused on negative experiences in this helping population such as burnout, vicarious trauma, secondary traumatic stress and compassion fatigue (Baldwin-White, 2016; Bride & Kintzle, 2011; Ewer et. al., 2015; Fahy, 2007; Perkins, 2013). A vast majority of the research on vicarious experiences of posttraumatic growth among other populations of helpers has largely been qualitative in nature and little research has been done in an attempt to quantify experiences of vicarious posttraumatic growth. Professional literature has indicated that professional helpers who experience burnout, compassion fatigue, and vicarious trauma can lead to deficits in quality of care (Oser et. al., 2013; Perkins, 2013). With a rise in the need for drug and alcohol treatment and an epidemic level of use of addictive substances, an ever growing populations of clients (NIDA, 2015; Young, 2015), and the need for quality helpers in the field of substance use disorder, a shift in research focus exploring professional quality of life as it relates to posttraumatic growth among drug and alcohol helpers is needed.

With a greater understanding of multifaceted nature of vicarious exposure to clients traumatic and stressful life events, and the unique challenges faced by drug and alcohol helpers, opportunities may be developed for the training, supervision, and education of this population of

helping professionals. These opportunities may lead to improvements in quality of care for substance users, increased self-care for drug and alcohol helpers, decreased turnover, improved supervision and training, as well as enhanced education for drug and alcohol helpers.

Implications for other helping professionals may also grow out of a greater understanding of the relationship between professional quality of life and posttraumatic growth. This quantitative study uses a survey based approach to explore the relationship of professional quality of life and posttraumatic growth among drug and alcohol helper's.

Participant Selection

The target population in this study included drug and alcohol helpers who had at least six months of providing direct clinical services to adults in treatment for substance use disorders.

The six-month experience minimum time frame for experience level was chosen for multiple reasons such as high turnover rates within the first year of working in the field (Eby, Burk, & Maher, 2010), as well as allowing potential participants to have had enough time working in the field to have both positive and negative experiences as a result of the work. This also allows for an increase in the diversity of the sample in terms of level of experience. In order to gain access to the target population of interest, participants will be purposefully selected for the study.

Criteria were created in which potential participants needed to meet in order to participant in the study. This criterion included having at least six months of experience as a drug and alcohol helper providing direct clinical services to individuals who had been diagnosed with substance use disorders as well as currently being employed as a drug and alcohol helper. Clinical services will be defined as providing individual counseling, group therapy, family therapy, and other therapeutic services that involve working directly with clients who have been diagnosed with substance use disorders. Substance use treatment center directors will be contacted via email and

asked to forward a request for participation to all clinical employees. In addition, recruitment letters for participation and recruitment flyers will be mailed through the postal service to drug and alcohol treatment facilities across the country asking that these documents be shared with clinical staff. Requests for participation will also be posted on counseling listserves and the recruitment flyer will be posted on social media sites in order to create a larger sampling pool and meet the sample size of $n=160$ which was determined using G*Power.

Willing participants will be provided electronic access to the study instruments. They will then review and agree to informed consent documents and agree to participation prior to any data collection. After participants agreeing to informed consent, they will be directed to the inclusion qualifying questions. Those who met inclusion criteria will then be directed to complete a brief demographic survey, the Professional Quality of Life Scale V (ProQOL V) (Stamm, 2010) and the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996). All data collection will be done electronically through the online service Qualtrics.

Data Collection & Data Analysis

Data will be done via Qualtrics an online data collection service. After obtaining informed consent via Qualtrics, which will host a inclusion qualifying questionnaire, a brief demographic questionnaire, as well as the Professional Quality of Life Scale V (ProQol V) (Stamm, 2010) and the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996).

Data analysis will be done through SPSS using a multiple regression analysis. Multiple regression analysis was chosen to address the research questions in order to explain the relationship between each independent variable (compassion satisfaction, secondary traumatic stress, burnout, personal characteristics) and the dependent variable (posttraumatic growth).

Multiple regression analysis was chosen because it will allow identification of the strength of the

effect that the independent variables have on the dependent variable, as well as provide insight and understanding into how much the dependent variable will change as the independent variables change (Hardy & Bryman, 2004). Sample size will be determined based on G*Power analysis.

Definitions

Substance Use Disorder – The American Psychological Association (2013) defines substance use disorder as:

A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using substances despite significant substance-related problems in which at least two of the following occur within a 12-month period.

1. Taking the substance in larger amounts or for longer than you meant to
2. Wanting to cut down or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts you in danger
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)

11. Development of withdrawal symptoms, which can be relieved by taking more of the substance

Trauma – any event that causes disturbance, fear, anxiety, feeling overwhelmed, vulnerable, helpless, and alone as perceived by those who have some direct experience of the event (Levers, 2012 p.1).

Substance use helper – any individual who engages in a empathetic professional relationship and provides direct clinical services to individuals seeking treatment for substance use disorder

Burnout – a “state of physical, emotional, and mental exhaustion caused by long term involvement in emotionally demanding situations” (Figley, 1995 p. 11).

Compassion fatigue (CF) – “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995 p. 11).

Secondary traumatic stress (STS) – a condition similar to CF that results specifically from work with victims of trauma resulting in a negative feeling driven by fear (Stamm, 2010 p. 12).

Vicarious Trauma (VT) – “a process through which the therapists inner experience is negatively transformed through empathic engagement with client’s trauma material” (Pearlman & Saakvitne, 1995 p. 280)

Posttraumatic Growth (PTG) – concept of positive personal change that results from a crisis or traumatic event (Tedeschi & Calhoun, 1996).

Compassion Satisfaction (CS) – “the pleasure derived from being able to do your work well...feeling positively about your colleagues or your ability to contribute to the work setting or even the greater good of society” (Stamm, 2010 p.12).

Vicarious Posttraumatic Growth (VPTG) – personal positive outcomes as a result of work with trauma survivors (Calhoun & Tedeschi, 1999).

Overview of Dissertation

In chapter 1, I have described the background of the study, the design of the study, the importance of the study, and its significance. In chapter 2, a review of the literature that includes an overview of the history and current state of the field of substance use disorder, treatment of substance use disorders, and drug and alcohol helpers in order to provide a baseline understanding of the population that is being focused on as well as the current state of professional literature in the arena of substance use. Differences between drug and alcohol helpers and other types of professional helpers will be discussed in order to distinguish the importance of examining experiences in this population of helpers compared to others. The impact of the therapeutic alliance with special attention to unique challenges of substance use disorder will be discussed. Negative impacts of helping professionals such as burnout, compassion fatigue and secondary traumatic stress, and vicarious trauma, with special attention to how these impact drug and alcohol helpers will be discussed. In addition to negative experiences, positive experiences of helping professionals such as compassion satisfaction and vicarious posttraumatic growth, with special attention to the impact on drug and alcohol helpers will be described.

Chapter 3 explains methodology and design of the study. In addition to methodology and study design a discussion participation selection, recruitment and criteria, data collection and analysis, and considerations for human ethics will be discussed. The primary purpose of this investigation is to explore positive changes drug and alcohol helpers have experienced as a result of their work. Relationships between subscales of the Professional Quality of Life Scale V

(ProQOL V), compassion satisfaction, secondary traumatic stress, and burnout, as it relates to posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI), will be discussed and implications for training, background, experience, and education will be explored. Chapter 4 provides the results of the data collection and analysis. Chapter 5 provides interpretation of analysis and implications for the field of drug and alcohol treatment, and suggestions for future study.

CHAPTER 2

Literature Review

A review of the literature is necessary to explore the constructs being studied and identify gaps that have been under explored. Chapter two provides a review of the research that has been conducted on drug and alcohol helpers professional quality of life as it relates to posttraumatic growth. The review of the literature includes a brief history of the development, and treatment, of substance use disorder, relationship between trauma and substance use disorder, costs and benefits of helping professionals, and characteristics/unique challenges of drug and alcohol helpers. This thorough review will also identify the gaps in the literature related to professional quality of life and posttraumatic growth among drug and alcohol helpers and demonstrate the need for exploratory, quantitative study on professional quality of life and posttraumatic growth among drug and alcohol helpers.

History of Substance Use Disorder Treatment

The use of psychoactive substances dates back to the earliest recordings of human kind and to date the impact of using psychoactive substances continues to impact humanity on individual, family, and societal levels of everyday life. Early documentation of substance use can be seen appearing across cultures, ancient Egypt, China, Greeks, all have documentation of the use of substances within their cultures (Katcher, 1993; Robinson & Adinoff, 2016; Saah, 2005). Substance use has also been well documented in relation to religious practices, the bible, which refers to the use of substances in thousands of passages, describes the excessive use of alcohol as sinful, some of the first insights into the societal problems that can arise as a result of excessive use of substances (Henninger & Sung, 2014; Robinson & Adinoff, 2016). Recordings of the early use of substances can also be found in literary master pieces such as Homer's *The*

Odyssey, “a drug that had the power of robbing grief and anger of their sting and banishing all painful memories” (Robinson & Adinoff, 2016). This depicts the long held use of psychoactive substances as a means of escape for human-kind and illustrates the potential for using substances as a means of escape from the real world.

From the ancient world to modern day society, the use of substances has long been a part of human history. The consequences of substance use can be seen throughout history, Alexander the Great’s passing in 323 BC was thought to have been provoked by multiple years of heavy drinking and Aristotle also described the consequences of excessive substance use warning of the dangers of drinking during pregnancy (Crocq, 2007; Davenport-Hines, 2003). Throughout the 18th century substance use of all kinds impacted almost every civilization threatening the working class in Europe, introduction of alcohol to the Native Americans, and addictive powers of opium throughout China and eventually across the world (Crocq, 2007; Davenport-Hines, 2003; Robinson & Adinoff, 2016). As humanity grew and advanced so did the nature of substance use however it wasn’t till American physician Benjamin Rush that substance use was characterized by the loss of control due to the substance instead of a moral failing of the individual (Crocq, 2007; Katcher, 1993; Robinson & Adinoff, 2016; White, 1998). This was the first time that individuals struggling with substance use were not villainized or stereotyped as having some sort of moral failing, weakness, or sinful nature.

The Early Years of Treatment

In the earliest years of America alcohol consumption was a central part of society however even then public drunkenness and over use of substances was not viewed as being socially acceptable and came with consequences (Henninger & Sue, 2013; Levine, 1978; Stolberg, 2006; White, 1998). Treatment for substance abuse began with alcohol addiction during

the late eighteenth and early nineteenth centuries. Individuals who suffered with addiction were unwillingly housed in a variety of places including jails, hospitals, and asylums, none of which were very effective in the treatment of addictions (Henninger & Sung, 2014; White, 2014). Throughout these early years' addictions were generally viewed as moral failings and thus were associated with much shame for those who suffered from addictions (Katcher, 1993; White, 1998).

Individuals affected by substance use disorders prior to the late eighteenth century had limited help available to them. At that time there was still beliefs throughout societies that individuals who suffered with substance use disorder believed that there was something fundamentally wrong with them and that they were weak minded, others sought help through religious organizations believing that they had been afflicted by demons and needed divine intervention (Katcher, 1993; Lemanski, 2001; Saah, 2005). It was not until the late eighteenth century that other options began to appear however these options seemed no better in that most individuals with substance use disorder were frequently incarcerated (Henninger & Sue, 2013; Rothman, 2001; White, 1998). Other options for individuals with substance use disorder at the time included hospitals (Henninger & Sue, 2013), but more commonly individuals went to almshouses and asylums for the mentally ill (Henninger & Sue, 2013; Rosenberg, 1995; White, 1998). It was not until a prominent physician named Benjamin Rush that treatment approaches began to shift from a purely religious and moral approach to incorporate medical interventions (Henninger & Sue, 2013; Robinson & Adinoff, 2016; White, 1998, 2014).

Benjamin Rush began his work with addictions during the second half of the eighteenth century when he challenged the societal view of using jails, almshouses (homeless shelters), and asylums to address addiction and instead proposed that “sober houses”, which utilized medical

and moral teachings, to treat substance use disorders (Henninger & Sue, 2016; Levine, 1978; Sournia, 1990; White, 1998). He was at the forefront of advocacy creating and distributing educational pamphlets that described both symptoms and consequences of substance use disorders (Levine, 1978; Lemanski, 2001; White, 1998). In addition to his advocacy work in educating others about substance use, Rush also focused on the treatment of substance use disorders by creating an early treatment methodology for substance use disorders which included cold baths, vomiting, bleeding, blistering, sweating the patient, and aversion therapy (Henninger & Sung, 2014; White, 1998). Benjamin Rush was one of the first advocates to fight the stigma of substance use disorder arguing that it was far more than a moral failing and that it required specialized treatment and medical intervention (White, 1998). He promoted collaboration among professionals and began to work with other physicians throughout the eighteenth and early nineteenth century. These collaborations with others led to identification of physical consequences of substance use disorders providing more concrete understandings of substance use disorder symptoms and awareness (Henninger & Sung, 2014). Another important figure in the history of substance use disorder was Dr. Magnus Huss, a Swedish physician, during the late 1800's he coined the term "alcoholism" to describe those who struggle with alcohol addictions (Henninger & Sung 2014; White, 1998, 2014). These advances by the medical community created an increase not only in knowledge of substance use disorders but also in approaches to help those who suffered with substance use disorders.

As knowledge increased regarding addiction so did scientific interest which also lead to institutionalization which resulted in the development of some of the first professional associations that focused on addictions. The American Association for the Cure of Inebriation (AACI) was the first professional association of addiction treatment services and began the fight

to change societal views of addiction, arguing that addictions were a disease that deserved professional treatment (Henninger & Sung, 2014; White, 1998). Asylums began to offer different types of addiction treatments including inpatient, short- or long- term stays, detoxification, as well as the first attempts at outpatient treatments (Brown, 1981; White, 1998). During this latter half of the nineteenth century private sanatoria, also known as lodges/retreats, began to open which provided specialized addiction treatment, however these were very expensive and primarily provided services to the very wealthy (Henninger & Sung, 2013; White, 1998). These were the first endeavors to create a continuum of care in the treatment of addictions (Henninger & Sung, 2014; White, 2014). This was a time of challenge to societal beliefs and treatments of those who struggled with addictions shifting away from a view of criminality and moral failing towards a disease model perspective (Lemanski, 2001; White, 1998). Although views of addiction began to shift towards a disease model, the fundamental philosophy regarding treatment of addictions continued to remain the same, with the primary focus being to isolate the person who suffered with addiction from society so that they would not be tempted to relapse (Henninger & Sung, 2014; White, 1998).

Prohibition Era & The Harrison Act

As treatment options were increasing as a result of physicians' interests in developing treatment approaches for addiction so did knowledge of the negative consequences of substance use. This increase in the knowledge base of the impact of substance use and the growing social issues related to alcohol abuse among Americans sparked the rise of the temperance movement (Burnham, 1968; Lemanski, 2001; White, 1998). A key way that the temperance movement impacted the field of substance use disorders was that it provided a new conceptualization of addiction and recovery. Recovery was conceptualized as total abstinence from substances rather

than moderation or replacement of consumption of beer with wine and spirits (Henninger & Sung, 2014; Katcher, 1993; White, 2014). This shift in the view of recovery remains a component of many modern-day treatment modalities of addiction. The temperance movement also led to the rise of the Prohibition Party which advocated, and eventually changed United States policy on alcohol, for alcohol to be illegal in the United States. In 1920 the Eighteenth Amendment was adopted which criminalized the consumption of alcohol and in turn impacted the overall treatment of substance use in the United States (Katcher, 1993; Henninger & Sung, 2014).

Historically substance use disorders treatment focused on the use of alcohol however the early 1900's also saw an increase in the focus of addictions to psychotropic drugs (Heninger & Sung, 2014; White, 1998). Substances such as opiates and cocaine were becoming more and more available to people at this time with industrialization of society, trade routes opening up providing more access to other substances, as well as advances in the discovery of medicinal uses of other substances (Henninger & Sung, 2014; White, 1998; Stolberg, 2006). In contrast to the use of alcohol more women than men struggled with the use of psychotropic drugs, in part due to high likelihood of women being prescribed opiates as a form of treatment for menstruation and hysteria (Courtwright, 2001; Henninger & Sung, 2014; White, 1998). In addition to the applications of medical uses of psychotropic drugs and increase in trade routes psychotropic drugs were also legal up until 1914 when the Harrison Act was enacted (White, 1998). These events led to a shift in the focus of addiction with physicians increasing discussions that addiction was a disease and not a moral failure (White, 1998, 2014). Despite these shifts in the discussion of addictions the temperance movement was in full swing and stigma associated with substance abuse was very high which led to those suffering with

substance use to hide the problem from friends and family (Henninger & Sung, 2014; White, 1998). Stigmatization associated with substance abuse continues to plague those who suffer with substance use disorders to this day and presents unique challenges and barriers to the treatment of substance use disorders (Sattler, Escande, Racine, & Goritz, 2017; White, 2014).

Throughout the temperance movement and prohibition era alcohol addiction and psychotropic drug addiction continued to rise however the availability for treatment began to decrease and addictions were once again viewed negatively being associated with criminality, moral failings, and for those who were weak minded as opposed to a disease (Chandler, Fletcher, & Volkow, 2009; Henninger & Sung, 2014; Sattler et. al., 2017; White, 1998, 2014). The main treatment options available for individuals struggling with substance use disorders became religious in nature and was dominated by groups such as the Salvation Army, while institutional treatment options disappeared until later in the 1900s (Henninger & Sung, 2014; Lemanski, 2001; White, 2014). Organizations such as the Salvation Army continue to provide treatment for those affected by substance use disorder to this day and allowed for a continuation of treatment providers during a dark time in the history of addiction treatment history (Henninger & Sung, 2014; Lemanski, 2001; White, 1998).

With the rise of the Prohibition Party and the Harrison Act the criminalization of substance use also rose (Brown, 1981; Chandler et. al., 2009; Crocq, 2007). Individuals who struggled with substance use disorders became criminals instead of individuals suffering from a disease. This also led to a shift from a public health model of treatment for substance users to a criminal justice model approach to treatment (Brown, 1981; Courtwright, 2001; Henninger & Sung, 2014; White, 1998, 2014). At this time an individual who suffered with substance use disorders became demonized as criminals who needed to be sent away to mandatory (court

ordered) psychiatric treatment and/or locked away in jails (Chandler et. al., 2009; Henninger & Sung, 2014; White, 1998). Between the years of 1915-1929 drug and alcohol related incarceration increased exponentially, leading to overcrowding in jails and the creation of “narcotic farms” (Henninger & Sung, 2014; White, 1998, 2014). White (1998) described “narcotics farms” as early attempts by the criminal justice system to develop substance use disorders treatment centers within the criminal justice system. The treatment for addiction throughout this time in history primarily took one of three approaches, religious, legal, and medical. Most treatment approaches were also untested, exploratory in nature such as insulin-induced comas, electroconvulsive therapy, aversion therapy, psychosurgery such as lobotomy’s, and the only psychological approaches applied at this time were psychoanalytic (Feberman, 2004; Henninger & Sung, 2014; Lemanski, 2001; White, 2014). This was the primary mode of treatment for substance use disorders throughout the early nineteenth century and laid the groundwork for furthering the understanding of substance use disorders as well as continue to impact modern day substance use disorders treatment modalities.

The Modern Movement

The mid 1900’s were highlighted by the end of the Prohibition Party and the Twenty-first Amendment was passing which ended prohibition and created a new era for addiction treatments (Levine & Reinerman, 2004; White, 1998). The “Modern Alcoholism Movement” (1933-1955) was born and once again alcoholism was once again defined and described as a disease which led to definitions associated with addiction being a public health problem that could be treated and not a merely a moral weakness (Henninger & Sung, 2014; Roizen, 2004; White, 1998). This shift in perspective was the beginning of the development of modern day treatment options for substance use disorders (Roizen, 2004; White, 1998).

Substance use disorders and treatment options continued to gain interest from the fields of medicine, psychology, and social work which led to new research providing credibility to the field as well as new theoretical models and techniques to address substance use disorders (Levine, 1978; MacAndrew & Edgerton, 1969; White, 1998). Prior to this period of time the primary providers of treatment were made up of professionals in the fields of medicine, criminal justice, and religious organizations however that began to shift as an increase in helping professionals, such as psychologists and social workers, began to invest interest in addictions (Robinson & Andinoff, 2016; Roizen, 2004; White, 1998, 2014). As interest from helping professionals grew so did professional organizations, three of which were Research Council on Problems of Alcohol, the Yale Center for Alcohol Studies, and the National Committee for Education on Alcoholism (Henninger & Sung, 2014; Roizen, 2004; White, 1998). These three professional groups made significant contributions in the areas of treatment in the workplace, policy change, treatment practices, advocacy to gain funding for research, education, and development of new interventions for substance use disorders treatment (Lemanski, 2001; Henninger & Sung, 2014; Robinson & Andioff, 2016; Roizen, 2004). These organizations were instrumental in the development of gaining a deeper understanding into the nature of substance use disorders, providing new frameworks to utilize in research and treatment of substance use disorders that continue to inform current understandings of substance use disorders (Henninger & Sung, 2014; Roizen, 2004; White, 1998, 2000b).

Although the field of substance use disorders was growing and the importance of providing treatment for those with substance use disorders was identified it was not until a self-help group formed that the field underwent a major paradigm shift that continues to be a main tenet of treatment today. The group was called Alcoholics Anonymous (A.A.), a self-help

recovery group that was formed by individuals who, they themselves, struggled with alcoholism (Henninger & Sung, 2014; Robinson & Adinoff, 2016; Roizen, 2004; White, 1998, 2000b, 2014). A.A. has had tremendous impact on the field of substance use disorders including the wounded healer movement, substance use helper qualifications, treatment approaches and modalities, research practices, supervision techniques, professional helper challenges and characteristics, as well as continuing care planning (Henninger & Sung, 2014; Kelly, 2017; Nace, 2015; White, 1998;). A.A. evolved out of a group known as the Oxford Group, a spiritual group that sought to use spirituality to enacted societal change (Alcoholics Anonymous, 2001; Gorsuch, 1995; Hazelden, 2017; Henninger & Sung, 2014; White, 2000b). Not all members of the Oxford Group were supportive of addressing addictions through their group and did not want the primary focus of the group to be on sobriety, this led to a division in the Oxford Group and the birth of A.A (Lemanski, 2001; Henninger & Sung, 2014; White, 2014). With the leader ship of Bill Wilson, one of the founders of A.A., and Dr. Robert Smith, co-founder of A.A., Alcoholics Anonymous sprung out of the Oxford Group (White, 1998; White, 2000b).

Bill Wilson and Dr. Robert Smith developed Alcoholics Anonymous to be a financially independent group that outlined a new era of treatment and recovery from alcoholism (Nace, 2015; White, 1998). Wilson wrote a book called Alcoholics Anonymous which provided a framework of recovery incorporating guiding principles and twelve steps to sobriety, the focus of which was on how to achieve sobriety instead of what caused the alcoholism (Alcoholics Anonymous, 2001; Nace, 2015). The development of Alcoholics Anonymous also began to have a pivotal role in the world of addiction treatments. Members of A.A. began to play an important role in the treatment of addictions by making it their goal to change the perceptions of alcoholism (White, 2014). This began a new era of substance use disorder helpers and marks the

shift of whom was best suited to treat addictions, professionally trained versus non-professionally trained (Henninger & Sung, 2014; White, 1998; White, 2000a; White, 2000b).

A.A. members made significant contributions to the field through advocacy, speaking with hospitals and medical professionals about addiction as a treatable disease (White, 1998; White, 2000a; White, 2000b). Members also provided knowledge on how to treat alcoholism based on the Alcoholics Anonymous book. In addition, A.A. members advocated to develop separate treatments with the sole purpose of treating alcoholism and suggested that these treatment wards be managed by A.A. members to reduce hospital staff stress and promised to pay hospital bills for any patient that A.A. members sponsored for treatment (Henninger & Sung, 2014; White, 2000a; White, 2000b; White, 2014). The main approach of A.A. was to use group members personal experiences of alcoholism and recovery to support the process of recovering from alcoholism (White, 2014), an approach that became intertwined with treatment approaches and continues to be intertwined with treatment approaches to this day. This was a significant shift in treatment provider qualifications and the wounded healer movement in the field of substance use disorders. Wounded healers consisted of individuals who have no previous professional training or education but instead have they themselves struggled with addiction and have achieved recovery, making them uniquely qualified to provide treatment to others who struggle with substance use disorders (White, 1998; White, 2000a; White, 2000b).

The wounded healer impact on the field of substance use disorders treatment continues to impact treatment of substance use disorders to this day and is unique to the field of substance use disorders helpers. This shift in the conceptualization of addictions treatment and who is best qualified to treat substance use disorders has created unique characteristics in the make-up of this population helping professionals. Unique to the field of substance use disorders treatment

include characteristics of helping professions who do not possess qualification, education, or credentials in a helping profession however are themselves in recovery from a substance use disorder (Ogbome & Evces, 2015; White, 2000a; White, 2000b). Substance use disorder helping professions educational backgrounds ranges from no post-secondary to doctoral training as well as specialized certification and licensure (Hazelden, 2017; Janikowski & Glover-Graf, 2003; Ogbome & Evces, 2015; NIDA, 2015; White, 2014). This has created a very diverse population of helping professionals as well as presents unique challenges to the provision of treatment of substance use disorders that continues in current treatment for substance use disorders.

The Minnesota Model

With A.A. in the forefront paving a new wave for substance use disorders treatment, the nature and framework for treatment began to transform towards the development of specialized professional treatment centers with the sole purpose of treatment substance use disorders (Henninger & Sung, 2014; White, 1998; White, 2000a; White, 2000b). Three organization in particular became fundamental in the development of substance use disorders treatment with the development of a new model of care called the “Minnesota Model” (Hazelden, 2017; Henninger & Sung, 2014; Nace, 2015; White, 2014). Willmar State Hospital, Pioneer House, and Hazelden, were located in Minnesota and in the late 1940s they proposed a new treatment to alcoholism based on the tenets of the A.A model (Anderson, McGovern, & DuPoint, 1999; Hazelden, 2017; White, 2014). The primary principle of the Minnesota Model centered treatment towards respect for those who suffer with substance use disorders (Anderson et. al., 1999; Hazelden, 2017; White, 2014). Each of the treatment centers contributed to the development of the model which proposed that patients would benefit from a recovery process founded in mutual respect and

redefined alcoholism as “not as a symptom of underlying emotional problems, but as a primary, progressive disease” (White, 1998, p. 203).

The Minnesota Model also encompassed the view that treatment should use integrative and holistic approach, which identified professionals are a key component of addiction treatment (Anderson et. al., 1999; White, 2014). The Minnesota model also aided in the wounded healer movement in that it highlighted the importance of recovered alcoholics as professionals, also known as ‘lay therapists’ or ‘wounded healers’, and the incorporation of providing them with specialized trainings and credentialing (Anderson et. al., 1999; Hazelden, 2017; White, 2000b; White, 2014). The Minnesota model centered around the belief that those who have recovered from alcohol/other drugs were the best individuals to provide counseling to patients (Henninger & Sung, 2014; White, 1998; White, 2000b). The professionalization of individuals with substance use disorders has become a routine occurrence in current treatment models and provides both benefits and challenges to modern day substance use helpers.

The Minnesota model thrived throughout the 1960s and continued to play an important role in the development of addiction treatment adding many core elements to our modern day understanding of substance use disorder treatment (Anderson et. al., 1999; Hazelden, 2017; White, 2014). Some elements of the Minnesota model include a standard 28-day stay for inpatient treatment, utilizing medications to help the detoxification process, each patient being assigned a counselor whom was often a recovered addict themselves, matching counselors’ gender and age with a patient, provision of supportive environment which encourages self-disclosure, group counseling, psychoeducational lectures, as well as incorporation of the twelve steps of A.A. (Anderson et. al., 1999; Hazelden, 2017; Lemanski, 2001; Henninger & Sung, 2014; White, 1998; White, 2014). The Minnesota model innovated the way that substance use

disorders are treated and has had a huge impact on the development of substance use helpers as well as substance use disorder treatment that continues to impact current treatment providers.

History of Substance Use Helpers

Although there is a long history and evolution of the treatment of substance use disorders, the history of substance use helpers did not begin till the early nineteenth century with the “lay therapy” “wounded healer” movement (White, 2000a; White, 2000b; White 2014). Courtenay Baylor, often referred to as the first lay therapist, was detrimental in the earliest stages of substance use helpers by developing a group of addiction treatment providers who had participated in treatment themselves (Hagedorn, Culbreth, & Cashwell, 2012). Thus the primary qualification that substance use helpers was their own personal recovery status, which quickly became the norm in the population of substance use helpers (Hagedorn et. al., 2012; White, 2000b). As the field of substance use disorder treatment evolved with the development of A.A. the wounded healer approach to treatment also increased. This was further fueled by A.A. members opening “retreats”, now known as halfway houses, treatment centers, and the increase in need for substance use helpers (Mustaine, West, & Wyrick, 2003; Ogborne, Braun, & Schmidt, 2001; Ottenberg, 1977; White, 2014).

The wounded healers’ movement and the population of substance use helpers was heavily consisted of individuals who lacked professional education and training in field of counseling (Henninger & Sung, 2014; White, 2004). Up until the 1970s there was no options for substance use helpers to gain advanced training and education surrounding professional helping (White, 2000a; White, 2004; White, 2014). At this time the National Institute for Alcoholism and Alcohol Abuse (NIAAA) and the National Institute for Drug Abuse (NIDA) began offering formal training programs that substance use counselors began to engage in further education and

training (White, 2000a). This group of wounded healers, individuals who themselves were in recovery, whom had no formalized education in a helping profession were the primary counselors in the field of substance use treatment and continue to be a significant part of the substance use helpers population to date.

The 1980s brought about a shift in the addiction counseling population as individuals with formal training and education in counseling began to enter the field of substance use disorders treatment (Henninger & Sung, 2014; White, 2014). The professionally trained addiction counselors shifted the focus of treatment from personal experience and recovery status, towards reliance on education and training in providing treatment (White, 2014). This led to a diverse population of substance use helpers towards a variety of educational level, recovery background, experience, and credentials (Hagedorn et. al., 2012; White, 2004; White, 2014). This shift in the demographic make-up of the addiction counseling population led to the ongoing debate of what makes a helper most effective in working with individuals who suffer with substance use disorder, those in recovery themselves or those with formal education and training (Hagedorn et. al., 2012).

Diversity within the population of substance use helpers continues to be present to date with substance use helpers providing direct clinical care who have a wide range of education, training, credentials, and recovery status. In addition to continued diversity in terms of qualifications for substance use helpers the debate over what makes the best addiction counselor (education vs experience). The diversity among qualifications of the population of helpers also impacts the population of supervisors within this field which contributes to unique systemic impacts on the field of substance use disorders treatment. Some of the unique challenges that this population of helpers' face include varying levels of education, training, high client deaths,

mismatches in supervisor-supervisee education and training background, high rates of staff turnover, lowered pay ranges, high rates of client relapse, and high rates of co-occurring disorders and client trauma background (Anderson et. al., 1999; Bride et. al., 2009; Brown, 1981; Brown, Stout, & Mueller, 1999; Henninger & Sung, 2014; Mustaine et. al., 2003; Ogborne et. al., 2001; Toriello & Benshoff, 2003; White, 2004; White, 2014). These are unique challenges to substance use disorders helpers and bring with them a variety of unique challenges within the treatment setting. The history of substance use disorder treatment and development of substance use disorder counselors provides a foundation for our understanding of multiple contributing factors impacting substance use disorders counselors. The history of this helping population and its impact on the diversity within the demographic make-up of this population also provides a foundational understanding of how constructs such as burnout, secondary traumatic stress, compassion satisfaction, and posttraumatic growth may be experienced differently by this population of helpers.

Price of the Helping Relationship

Exploration into the risks of providing counseling to individuals struggling with mental health as well as substance use has momentarily been documented throughout professional literature. Helpers who engage in empathic, therapeutic, work with individuals seeking treatment can experience a range of psychological impairments. The secondary, vicarious, exposure to client's experiences can take a range of forms and can present co-occurring as well as in isolation. Research into the negative impact of engaging in therapeutic work has resulted in the development of multiple constructs to describe these experiences however there continues to be confusion regarding distinguishing constructs from each other and over use of interchanging constructs. Some of these constructs which will be explored further in the following sections

include burnout, compassion fatigue/secondary traumatic stress, and vicarious trauma. In order to fully understand these constructs the relationship between professional helper and client must be explored, the following section reviews the literature on helping relationships.

Impact of client experiences on the helping professional was first viewed through the construct of counter-transference proposed by Freud. Freud (1910) discussed the importance of raising awareness around the influence of patients on the helpers unconscious feelings. Counter transference has exhaustingly been researched as a factor that can intrude and disrupt the therapeutic process and has been described as something which must be addressed in order to provide effect treatment (Fuertes, Gelso, Owen, & Cheng, 2013; Wilson, 1995; Hayes, 2004; Rudd & Joiner, 1997; Safran, & Kraus, 2014; Schneider, 2005).

As the field of helping has evolved through the years, the interpretation of counter transference has also evolved and can be viewed as a normal aspect of the relationship between helper and client (Fuertes et. al., 2013). Helpers empathic reactions can be related to exposure to information related to client's experiences and can also have an impact on the helpers themselves (Abend, 1989; Ni, Hou, & Shao, 2011; Rudd, & Joiner, 1997; Safran, 2014). Personal characteristics of helping professionals are central to the development of counter transference (Fuertes et. al., 2013; Parth, Datz, Seidman, & Loffler-Stastka, 2017). Development of counter transference has been described as arising out of client's emotionally disturbing experiences, but revolving around the professional helpers preceding self, such as personal addiction issues, inner conflict, and unconscious processes (Hayes, 2004; Imhof, 1991).

Substance use disorder treatment varies from many other helping professions in that the roots of substance use treatment are grounded in the lay therapist movement (Anderson et. al., 1999; Henninger & Sung, 2014; White, 2000a; White, 2000b; White, 2004; White, 2014).

Historical perspectives on the treatment of substance use disorder, discussed in the previous section, show higher rates of personal connection to issues surrounding substance use within this population of helpers in comparison to other helping professionals (White, 2000a). In addition to higher rates of personal connection issues, substance use helpers face other barriers that are unique from other helping professionals. Substance use helpers are confronted with higher levels of client resistance (Gastfriend, 1996; Hyde, 2013), high levels of relapses and client mortality (Bergman et al., 2016), violence towards helpers (Bride, Choi, & Roman, 2015), as well as requirements for less training, clients experiencing multiple life problems (Oser et. al., 2013), high levels of trauma and high levels of co-morbidity (Keyser-Marcus et. al., 2015; Najavits, Hyman, Ruglass, Hien, & Read, 2017). Due to the high rates of personal connection to related issues of substance use within this population of helpers, as well as the unique challenges that this population of helpers' face on a regular basis, the population of substance use helpers is at a high risk of developing negative reactions to clients such as burnout, compassion fatigue, and secondary traumatic stress. The following sections will review the professional literature on these negative reactions with special attention paid to substance use helpers experiences of these negative reactions.

Burnout

Burnout has been a concept of research focus in the helping field for decades however it is important to note that burnout is not a phenomenon that is specific to the helping profession. Merriam-Webster dictionary defines burnout as “exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration”. In terms of the helping profession burnout has been described in multiple ways, one definition of burnout in terms of the helping profession is the price that helping professionals pay for caring for others (Maslach,

Schaufeli, & Leiter, 2001). Although definitions of burnout have varied throughout the years there has been a consistent aspect of negative emotional response on behalf of a helper as a result of working with people in stressful and emotionally intense situations (Figley, 1998; Figley, 2001; Maslach et al., 2001). One definition of burnout has been described in a three-dimensional perspective of (1) emotional exhaustion, (2) depersonalization, and (3) lack of personal accomplishment (Shoptaw, Stein, & Rawson, 2000). Another has defined burnout as mode of being physically, emotionally, and mentally exhausted, the cause of which is related to long term engagement with emotionally demanding situations (Figley, 1995, p. 11). Figley (1995), asserted that burnout is primarily related to stressors within the workplace. Thus burnout is related to emotionally stressful and draining consequences that stems from a job stress (Figley, 1995). Burnout in the field of substance use disorders has identified a number of factors associated with the experience some of which include personal characteristics such as age, educational level, recovery status, as well as organizational characteristics such as pay rate, location, caseload, available resources, autonomy, and role expectations (Ducharme, Knudsen, & Roman, 2008; Knudsen, Ducharme, & Roman, 2008; MucNulty et al. 2007, Oser et al., 2013).

The cost of burnout impacts all dimensions of the helping profession including organizations, counselors, and clients (Oser et al., 2013). Organizations can face high rates of absenteeism and turnover, which can result in additional financial support to recruitment, hiring, and training new staff (Maslach, Jackson, & Leiter, 1997). In addition to organizational costs counselors also experience consequences as a result of burnout. Burnout in counselors can result in higher levels of stress-related illness and mental health issues such as depression, anxiety, decreased self-esteem, increased physical health problems such as insomnia, headaches, and general overall illnesses (Ducharme, Knudsen, & Roman, 2008; Pines & Maslach, 1978). Clients

who have counselors that are experiencing burnout face a lack of continuity of counselor care, prematurely withdrawing from treatment due to inconsistent and/or inadequate care (Oser et al., 2013). Professional literature indicates that those who work in the substance use helping profession are at risk of facing over 100 factors associated with burnout (Aiken & Sloane, 1997). With substance use helpers being at risk of facing a wide range of factors associated with burnout it is important to further our understanding of how to define and measure burnout. This can also lead to further investigation of how burnout might impact the field of substance use disorders treatment and how it might relate to potential positive experiences by substance use helpers.

The Maslach Burnout Inventory-Human Services Survey (MBI), is one of the most widely accepted and validated measure of burnout (Maslach & Jackson, 1981; Maslach, Jackson, & Leiter, 1997). The MBI was designed to assess levels of influence and assesses three fundamental aspects of burnout which are broken into three subscales: (1) emotional exhaustion, (2) depersonalization, and (3) feelings of competence (Maslach & Jackson, 1981). The first subscale, emotional exhaustion, measures the degree to which helpers feel emotionally extended beyond a safe point and exhausted as a result of the work they do (Maslach & Jackson, 1981; Maslach, Jackson, Leiter, 1997). The second subscale, depersonalization, refers to the degree to which helpers experience a lack of engaging in personal responses and/or a numbing towards clients' circumstances (Maslach & Jackson, 1981; Maslach, Jackson, Leiter, 1997). Lastly the third subscale, feelings of competence, refers to helpers' sense of impact of their work, or their effectiveness and success at work (Maslach & Jackson, 1981; Maslach, Jackson, Leiter, 1997). These three fundamental aspects of burnout have been well researched throughout the years with the most common symptom being described as exhaustion (Maslach, et al., 2001).

Reliability of the MBI show internal consistency estimated by Cronbach's alpha for frequency $\alpha=0.83$ and intensity $\alpha=0.84$ for the overall scale (Maslach & Jackson, 1981). Reliability for the subscales has also been assessed for frequency and intensity, Emotional Exhaustion subscale $\alpha= 0.89$ (frequency) and 0.86 (intensity), Personal Accomplishment $\alpha= 0.74$ (frequency) and 0.74 (intensity), Depersonalization $\alpha= 0.77$ (frequency) and 0.72 (intensity), and Involvement $\alpha= 0.59$ (frequency) and 0.57 (intensity) (Maslach & Jackson, 1981). Test-retest reliability of the MBI showed reliability coefficients for subscales as well with Emotional Exhaustion $\alpha= 0.80$ (frequency) and 0.53 (intensity), Personal Accomplishment $\alpha= 0.80$ (frequency) and 0.68 (intensity), Depersonalization $\alpha= 0.60$ (frequency) and 0.69 (intensity), and Involvement $\alpha=0.64$ (frequency) and 0.65 (intensity) (Maslach & Jackson, 1981).

Factors that have been associated with burnout have also been thoroughly researched throughout the professional literature in order to gain insights into what places helpers at risk for the development of burnout. Demographic factors such as age, gender, exposure level, training, personal history, and experience level have been some of the commonly investigated variables to be studied for burnout (Ben-Porat & Itzhaky, 2011; Canfield, 2005; Hunsaker, Chen, Maughan, & Heaston, 2015; Oser et. al., 2013; Perkins & Sprang, 2013; Pines & Maslach, 1978; Wagaman, Geiger, Shockley, & Segal, 2015). In addition to certain demographic characteristics there have been multiple studies that indicate a correlation between personality type, age, and personal history playing a role in the development of burnout for counselors (Lee, Veach, MacFarlane, & LeRoy, 2015; Lent & Schwartz, 2012; Rzeszutek & Schier, 2014).

Moore and Cooper (1996), found that individuals who show personality traits that are competitive, time conscious, ambitions, or Type A personalities, are more likely to suffer from burnout than other personality types. In terms of substance use helpers, the research is

inconsistent on the impact of recovery status on burnout (Aiken & Sloane, 1997; Baldwin-White, 2016; Elman & Dowd, 1997; Fahy, 2007; Oser et. al., 2013; Young, 2015). Some studies show that those who are in recovery from substance use exhibit higher rates of burnout than those who did not identify as being in recovery (McNulty et al, 2007; Rubington, 1984). However, a study done by Elman and Dowd (1997), indicated that recovery status was not a significant predictor of burnout and that those in recovery may even have more protective factors due to their support system associated with their recovery status. Inconsistency in the current body of literature indicates a need for increased investigation into potential relationships between recovery status and burnout.

Organizational atmosphere and environment have been shown to have a strong relationship with the development of burnout (Figley, 1995). Everyday stressors and pressure associated with work with troubled, difficult populations increase the risk of developing burnout (Bride, 2004; Bride & Kintzle, 2011; Canfield, 2005; Maslach, Schaufeli, 2001). If burnout is not addressed the consequences of burnout become more severe and can lead to increased impairments of helping professionals (Everall & Paulson, 2004; Skorupa & Agresti, 1993). Helping professionals as well as supervisors and peers, have an ethical responsibility to monitor for any symptoms of burnout. This responsibility is outlined in the American Counseling Associations code of ethics (C.2.g) which describes the importance of recognizing impairment.

The consequences of burnout have been thoroughly research and along with those consequences the professional body of literature has also extensively explored prevention and protective factors to fight off or decrease burnout. Among some of the well-researched self-care strategies discussed throughout the literature on burnout, meditation, visualization, exercise, increased breaks in routine, increased time off work, smaller caseloads are just some of the

techniques that can combat burnout (Figley, 1995; Maslach, 2017; Maslach & Goldberg, 1998). In addition to self-care and coping strategies, helpers also require quality clinical supervision which provides a safe environment to explore the impact of the work they do and identification of outlets and resources for management of symptoms of burnout (Edwards et al., 2006; Figley, 1995; Maslach & Goldberg, 1998). Lastly, education and training surrounding the risk and development, symptoms, prevention, and treatment of burnout should be included for all helping professions but may be exceptionally well deserved for substance use helpers given the varied levels of educational background that they come from. Organizations can also provide increased opportunities for professional development, peer-consultation, and group supervision when addressing burnout in order to help reduce stigma associated with burnout (Everall & Paulson; Pearlman & Saakvitne, 1995).

Compassion Fatigue/Secondary Traumatic Stress

Compassion fatigue (CF) is described as the natural response from the desire to want to help traumatized individuals which results from an emotional response to knowledge of a traumatic event (Figley, 1995). Compassion fatigue originated out of Figley's (1995) studies of what he had called 'burnout' or 'secondary victimization'. As Figley (1995) expanded his research he found that empathizing with, and providing emotional support to victims of trauma resulted in psychological strain on the helping professionals. Compassion fatigue was defined as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p.7). Stamm (2010), described compassion fatigue as a two part construct which incorporates both burnout and secondary traumatic stress.

Secondary Traumatic Stress (STS), first emerged from research that Figley (1983) had been conducting on the vicarious reactions to traumatic stress by examining the experiences of family members who had secondary exposure to loved one's trauma. Figley (1995) found that caregiver reactions imitated PTSD symptoms that those who had directly experienced the trauma exhibited. One of the key features that differentiates secondary traumatic stress from burnout is the cause, which is a result of hearing emotionally disturbing material from clients (Canfield, 2005). Secondary traumatic stress is the result of work-related, secondary exposure to others who have experienced extremely, and/or traumatically, stressful events (Stamm, 2010). Much like burnout secondary traumatic stress is depicted by depression, insomnia, fear, intrusive images, avoidance, and a loss of emotional engagement with friends and family (Canfield, 2005; Stamm, 2010). One primary difference that separates secondary traumatic stress from burnout and compassion fatigue is that burnout and compassion fatigue can occur with any type of work whereas secondary traumatic stress is specific to helping professionals and work with victims of trauma as well as symptoms associated with fear (Ben-Porat & Itzhaky, 2011; Dunkley & Whelan, 2006; Stamm, 2010).

A wide array of instruments has been developed in order to measure compassion fatigue and secondary traumatic stress. Figley (1995) was the first to develop a measurement of compassion fatigue coined the Compassion Fatigue Self Test. Multiple versions of the Compassion Fatigue Self Test have been created and used to assess both compassion fatigue as well as secondary victimization (Stamm, 2010). The Professional Quality of Life Scale (ProQOL), has been in use in professional settings since 1995 and has gone through multiple revisions with the most current being the ProQOL V. The ProQOL V contains three subscales: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (Stamm, 2010). The ProQOL

V will be discussed in further detail later in this literature review however it is worth noting here that it is a widely used instrument in the measurement of compassion fatigue, burnout, and secondary traumatic stress (Stamm, 2010).

Advantages of Helping

Although there seems to be a largely negative and pathologizing focus in the professional research on the helping field, a shift towards a more positive and optimistic approaches have been developing since the mid 1900s (Seligman & Csikszentmihalyi, 2000). This shift towards wellness and how people thrive can be seen when Abraham Maslow shifted his focus from a negative view towards a more positive connotation of psychology (Lopez & Snyder, 2009). Thus, the beginnings of the positive psychology movement were born. Although the beginnings of positive psychology can be traced back to Maslow it was not until Martin Selgiman coined the term ‘positive psychology’ as “the scientific study of what makes life most worth living” that the field gained momentum for research and application in helping professions (Lopez & Snyder, 2009, pxxi; Seligman, 2002).

Positive psychology has been applied to a variety of helping professionals which has resulted into research that investigates growth following adversity. Research into “what makes life most worth living” has given rise to multiple constructs including resilience, compassion satisfaction, and posttraumatic growth (Bonanno, 2004; Stamm, 2010; Tedeschi & Calhoun, 1996; Werner, 1995). Although this area of interest has begun to gain momentum in the world of research little attention has been paid to the application of positive psychology and substance use helpers. In addition to little research on potential relationship between positive psychology and substance use helpers’ constructs describing potential growth such as compassion satisfaction, resilience, posttraumatic growth, and thriving have been used interchangeably. The following

sections will outline the previous literature on positive constructs as well as provide parameters for defining and differentiating them from each other.

Resilience

The word resilience is defined as “the power or ability to return to the original form, position, etc., after being bent, compressed, or stretched; elasticity” (Merriam-Webster). In the field of helping, early investigation into the construct of resilience sprung out of exploration of protective factors that guard against adversities (Werner, 1995). In addition to exploration into protective factors research into wellness and identifying characteristics of individuals who are able to adjust versus those who succumb to the difficulties brought about by adversity have been central in the development of the construct of resilience (Fletcher & Sarkar, 2013). Much of this early research has defined resilience as emotional stamina, a buffering factor, and protective factors that promote development of positive outcomes (Luthar, Cicchetti, & Becker, 2000; Wagnild & Young, 1990; Werner, 1995; Rutter, 1978). A wide array of definitions of resilience can lead to inconsistencies and applicability in regard to policy and interventions in the helping professions (Kolar, 2011). Much of these early explorations into the concept of resilience focused on younger individuals whom experienced adversity, as well as focused on identifying protective factors, which seemed to guard against pathology (Luthar, Cicchetti, & Becker, 2000).

Much of the current literature on resiliency in adults is defined as an individual’s ability to maintain a stable level of balanced functioning, both physical and psychological, despite experiencing a traumatic or adverse event (Bonanno, 2004; Bonanno & Mancini, 2008; Bonanno, Westphal, & Mancini, 2011). These individuals who experience resilient responses to a traumatic or adverse event demonstrate the capability to withstand negative consequences of the event, which is one type of positive response (Green, Calhoun, Dennis, & Beckham, 2010). The

ability to respond to adversity and uphold healthy levels of functioning aids in differentiating resilience from recovery (Bonanno, 2004). Individuals who experience resilience show little to no change in their functioning (Schaubroeck, Rolli, Peng, & Spain, 2011). In contrast individuals who are able to recover experience a decrease in functioning resulting in disruption to their ability to function normally in their life for an extended period of time before they are able to begin to return to a healthy or normal level of engagement (Bonanno, 2008).

This distinction between recovery and resilience in the face of adversity provides insight into the conceptualization of resilience and in understanding one level of how individuals can experience a positive response to adversity. Although it is important to gain insight into how resilience is a separate construct than recovery it is also important to understand how it differs, and is a separate construct, from other positive responses to adversity. A clear, consistent definition of resilience is necessary in understanding its role in research, theory and clinical implications in helping professionals who are working with individuals who have experienced adversity. Substance use helpers work with clients who have experienced adversity and trauma on multiple levels (Jacobsen, Southwick, & Kosten, 2001; Morgan, 2009; Najavits et. al., 2013; Najavits et. al., 2017). Despite the adversity that substance use clients face they also show high levels of resilience, which substance use helpers are able to bear witness to (Mohammadi, Aghajani, & Zehtabvar, 2011).

Much like the research on resilience, the research on resilience and substance use disorders is largely focused on youth and adolescence (Rudzinski, McDonough, Gartner, & Strike, 2017). While resilience is viewed as a positive way to adapt to adversity in life, substance use is viewed as a maladaptive coping strategy (Bonfiglio, Renati, Hjemdal, & Friborg, 2016). Individuals with substance use disorders face multiple adversities as well as

stigma that goes along with the substance use disorder diagnosis (Birtel, Wood, & Kempa, 2017; Sattler, Escande, Racine, & Goritz, 2017; Yang, Wong, Grivel, & Hasin, 2017). The substance use helper utilizes the therapeutic process to help clients in building resilience to life stressors (Cadet, 2016). Some factors that can contribute to the development of resilience include social support, attachment to others and community (Bonanno, 2004; Cadet, 2016; Mohammadi, Aghajani, & Zehtabvar, 2011; Tzu & Damgaard, 2015). Social support, healthy attachments, and connection to community are all focus areas in the treatment of substance use disorders (Cadet, 2016; Mohammadi, Aghajani, & Zehtabvar, 2011).

Research on resilience provides a framework for understanding potential benefits following adversity however there is disagreement in the professional literature regarding commonality of resilience as well as definitions (Bonanno, 2004; Linley & Joseph, 2005). Some argue that resilience is more of a spectrum than a single construct and that it can be viewed as such with ranges that go from maladaptive, pathological responses, to adaptation, and moving beyond to growth following adversity (Linley & Joseph, 2005; Tedeschi & Calhoun, 2008; Park, Cohen, & Murch, 1996).

Posttraumatic Growth

The construct of resilience, the ability to uphold a healthy level of functioning, as one type of positive response to adversity and trauma (Bonanno, 2004), another type of positive response described in the literature can be understood through the construct of posttraumatic growth. Posttraumatic growth can be understood as positive changes in an individual's pre-trauma level of functioning as a result of struggles associated with the experience of a traumatic event (Bellizzi & Blank, 2006; Calhoun, Tedeschi, Cann, & Hanks, 2010; Tedeschi & Calhoun, 2004). The process of posttraumatic growth does not begin with a movement beyond previous

functioning but rather exposure to the traumatic event (Tedeschi & Calhoun, 2004). Exposure to a traumatic event provides an opportunity for posttraumatic growth to occur through the rebuilding of a new understanding of life that moves beyond previously held beliefs about life (Bellizzi & Blank, 2006; Tedeschi & Calhoun, 1996; Tedeschi & Calhoun, 2004). It is through this rebuilding of one's understanding of life, during which there is a significant struggle, that provides unique opportunity for growth beyond pre-trauma functioning (Bellizzi & Blank, 2006; Tedeschi & Calhoun, 1996; Tedeschi & Calhoun, 2004; Tedeschi & Calhoun, 2008; Triplett et al., 2012).

A significant body of literature has examined the construct of posttraumatic growth in regards to varying types of trauma such as loss of an unborn child (Krosch & Shakespeare-Finch, 2016), loss of a family member (Patrick & Henrie, 2016), natural disasters (Nalipay, Bernardo, & Mordeno, 2017), interpersonal violence (Elderton, Berry, & Chan, 2017), survivors of life threatening disease/illness (Bellizzi & Blank, 2006), as well as substance use (Stump & Smith, 2008). Research has identified multiple areas of an individual's life that can be impacted through the process of posttraumatic growth. Tedeschi and Calhoun (1996), suggested that those who support posttraumatic growth experience growth within five broad domains which are self-perception, new possibilities, interpersonal relationships, appreciation of life, and spirituality.

The first of the five domains that describe posttraumatic growth is self-perception. This domain is most commonly described as the change in self-perception is a recognition that there may be a sense of increased vulnerability but that also an increase in the sense that the individual is stronger, more equipped, and increased ability to survive than they had thought (Lee, Kim, Lim, & Kim, 2017; Tedeschi & Calhoun, 1996; Tedeschi & Calhoun, 2004). This can be

observed in studies of individuals who have gone through health crisis, such as cancer, who report feeling that they are stronger and increase sense of ability than they had previously thought they were (Ramos, Leal, Maroco, & Tedeschi, 2016). Those who report changes in self-perception see the changes as a result of the struggle that they endured.

The second domain points to an increased sense that the future is full of new prospects. Individuals who have suffered significant adversity and trauma may change the direction of their everyday lives in a way that adopts new, gung ho attitude towards life (Tedeschi & Calhoun, 1996, 2004; Triplett, Tedeschi, Cann, Calhoun, & Reeves, 2012). Some may they themselves get into a helping profession, others may travel the world, in general though the sense is that they are seeing things through a new lens that allows for a very “skies the limit” perspective and attitude to live each day to the fullest.

Individuals viewing improvement of their interpersonal relationships is the hallmark of the third domain that encompasses posttraumatic growth. Previous studies describe individuals reporting higher levels of appreciation for their friends and family as well as describing those relationships as deeper and more meaningful than they perceived them to be prior to experiencing a trauma (Tedeschi & Calhoun, 1996, 2004; Triplett et al., 2012). In addition, others have reported insights as a result of their trauma that express new desire to make the most of the time that they have with loved ones and the importance of relationships which resulted in changes to how they make and maintain relationships (Bellizzi & Blank, 2006; Calhoun, Tedeschi, Cann, & Hanks, 2010). Much like shifts in perceptions of interpersonal relationships the fourth domain involves changes in appreciation for life. This domain describes changes in overall value of life and individuals describe feelings associated with being given a second chance at life which they want to make the most of (Dekel, Mandl, & Solomon, 2011; Elderton

et al., 2017). Previous studies have documented these changes as individuals reporting spending an increased amount of time with family, deeper appreciation and focus on what they have, less focus on stressors or what they do not have (Arpawong, Sussman, Milam, Unger, Land, Sun, & Rohrbach, 2015; Tedeschi & Calhoun, 1996; Tedeschi & Calhoun, 2004; Joseph & Linley, 2006).

The last domain that encompasses posttraumatic growth is changes in spirituality. Individuals report a new and deeper sense of their spiritual beliefs and values that results from the struggle associated with the trauma they've experienced (McGrath, 2011; Paredes & Pereira, 2017; Schultz, Tallman, & Altmaier, 2010; Starnino, 2016). This may be described in terms of an individual describing the impact of their higher power helping them work through struggles associated with a trauma or as seen in the substance use field an individual describing how their higher power has helped them to remain in recovery and work through difficulties.

Gaining a clear understanding of the differences between conceptualizations of positive responses to adversity are crucial in understanding clinical implications as well as implications for future research. Insights into the conceptualization of these positive responses to trauma provide important implications for the helping professions. Solid understanding of the different types of positive responses to trauma provide relevance to the practice of working with individuals who have experienced trauma in moving away from a focus on pathology and promoting wellness in both victims of trauma, and individuals in the helping profession working with the trauma population.

Positive Approach to Helping

As the helping profession has begun to dive deeper into potential benefits following traumatic and adverse events for those whom experience them, research has also begun to explore positive approaches toward helping those individuals who have been exposed to trauma

and adversity. This growing body of literature has begun to investigate the benefits of working with trauma and adversity. Potential benefits have been described as increased interpersonal skills, appreciation for the human spirit, sense of the importance of their work, and increases in personal growth (Abel, Walker, Samios, & Morozow, 2014; Arnold, Calhoun, Tedeschi, & Cann, 2005; Cohen & Collens, 2013; Cosden, Sanford, Koch, & Lepore, 2016; Hyatt-Burkhart, 2014). Researchers have explored these vicarious positive responses in a variety of professions including health professionals (Manning-Jones, de Terte, & Stephens, 2017), interpreters (Splevins, Cohen, Joseph, Murray, & Bowley, 2010), disaster response workers (Linley & Joseph, 2006), mental health workers (Arnold et. al., 2005; Hyatt-Burkhart, 2014), and substance use helpers (Cosden, Sanford, Koch, & Lepore, 2016). Although the current body of professional literature has begun to investigate these vicarious positive responses much of the research has taken a qualitative approach with few providing empirical evidence. In addition, controversy over the self-report, retrospective nature of research into the construct has been noted as a limitation in understanding positive constructs. What follows is a discussion of major constructs that describe this shift in view of the helping relationship and positive approaches which provides a framework of understanding for the current study.

Compassion Satisfaction

Compassion satisfaction (CS), has been defined by Stamm (2010) as “the pleasure you derive from being able to do your work” and can further be described as feeling good about being able to help others and impacting the overall greater good of society as a result of helping others. Noted as a process that results from engaging with others in an empathic way, compassion satisfaction involves developing a stronger sense of self, self-knowledge, confidence, meaning, spiritual connection, and respect for individual’s resiliency (Stamm, 2009,

2010). Compassion satisfaction has been discussed as a method for addressing the negative aspects of helping such as burnout, compassion fatigue, and secondary traumatic stress and arguments have been made that suggest helpers can experience compassion satisfaction while also experiencing the negative effects of helping others (Stamm, 2010). Much the opposite of constructs such as burnout and secondary traumatic stress, compassion satisfaction has been associated with a sense of achievement, supportive of maintaining motivation, and a source of inspiration resulting from the emotionally demanding work that the helping profession is associated with (Wagaman, Geiger, Shockley, & Segal, 2015). These benefits come about as a result of helpers vicariously experiencing client's improvements in treatment as well as lead to situations that promote growth (Pooler, Wolfer, & Freeman, 2014).

There have been many factors, both individual and organizational, that have been associated with the development of compassion satisfaction. Some factors that have been described as contributing to higher levels of compassion satisfaction include higher levels of manager/supervisor support, older aged individuals, varying responsibilities related to the work they do, use of positive self-talk, maintaining work-life balance, prioritizing time with family and friends, utilizing vacation days for self-care, engaging in spiritual beliefs, engaging in continuing education and training, size of high trauma or difficult patient's in caseload, ability to see the benefits and bliss in helping others (Humsaker, Chen, Maughan, & Heaston, 2015; Hunter, 2012; Lawson & Myers, 2010; Stamm, 2010; Stevanovic & Rupert, 2004). Much of the research on compassion satisfaction has been explored through qualitative methods or through the use of the Professional Quality of Life Scale which is currently in its fifth version. The ProQOL 5 is a 30 item tool which has three subscales that measure compassion satisfaction, burnout, and

secondary traumatic stress/compassion fatigue and has been peer-reviewed in hundreds of articles (Stamm, 2010).

Vicarious Posttraumatic Growth

Research has long documented the dangers of helping professional's exposure to client's trauma and adversity, more recently in the professional literature a growing body of research has begun to explore the potential for growth. This growing body of literature has begun to explore the construct of vicarious posttraumatic growth (VPTG). Although investigations into the construct of vicarious posttraumatic growth continue to increase in the professional literature much of the research lacks empirical evidence and has largely been investigated from a qualitative and retrospective approach and more research is needed that utilize quantitative approaches to better understand the construct (Abel, Walker, Samios, & Marozow, 2014).

Despite the lack of empirical research on the construct of vicarious posttraumatic growth, many studies have explored the possibility of positive change in helping professionals resulting from adversity and trauma they may be exposed to (Abel et. al., 2014; Cosden et. al., 2016; Hyatt-Burkhart, 2014; Joseph & Linley, 2004, 2005). Previous research suggests that helping professionals who work with individuals who have experienced trauma and adversity show gains in sensitivity, compassion, insight, tolerance, empathy, and interpersonal relationships (Arnold et. al., 2005).

Research has also suggested that helping professionals show gains in three broad areas (self-perception, interpersonal relationships, and philosophy of life) that have also been used to describe vicarious posttraumatic growth (Abel et. al., 2014; Arnold et. al., 2005; Barrington & Shakespeare-Finch, 2013, 2014; Brockhouse, Msetfi, Cohen, & Joseph, 2011; Hyatt-Burkhart, 2014; Splevins, Cohen, Joseph, Murray, & Bowley, 2010). The limited research on vicarious

posttraumatic growth that provides empirical evidence utilizes the Posttraumatic Growth Inventory which is a 21 item self-report inventory, which encompasses a 5-factor structure made up of the domains of personal strength, new possibilities, relating to others, appreciation of life, and spiritual change (Arnold et. al., 2005; Brockhouse, Msetfi, Cohen, & Joseph, 2011; Cosden, Sanford, Koch, & Lepore, 2016; Tedeschi & Calhoun, 1996). Although this measure was initially created to assess individuals who had directly experienced a trauma it has been utilized in multiple studies to assess an individual who has been vicariously exposed to another's trauma, including multiple types of helping professionals (Abel et. al., 2014; Beck, Rivera, & Gable, 2017; Cosden et. al., 2016; Manning-Jones, de Terte, & Stephens, 2017).

Vicarious posttraumatic growth has investigated multiple populations of helping professionals however very little research has been conducted to explore how it may relate to substance use helpers. To this researchers' knowledge only one article has been published which investigates vicarious posttraumatic growth among substance use helpers and there appear to be multiple areas of limitation within that study. In the study done by Cosden et. al. (2016), some limitations include a very small sample size ($n=51$) which makes the results questionable in terms of generalizability, the sample was also collected from one county in California, the participants also reported high levels of training and supervision for practicing trauma-informed care. Although there have been studies that have investigated posttraumatic growth among substance users (Arpawong, Sussman, Milam, Unger, Land, Sun, & Rohrbach, 2015; Stump & Smith, 2008) very little has been done to investigate how this construct may be impacting those who work with substance use disorders. This study attempts to fill the gap in the literature surrounding substance use helpers' experiences of professional quality of life (compassion

satisfaction, secondary traumatic stress, and burnout) as it may relate to posttraumatic growth and move with the paradigm shift towards a positivistic approach.

Conceptual Framework

This study will take a quantitative, exploratory survey research approach which will utilize a correlational design to measure the relationship between professional quality of life (compassion satisfaction, secondary traumatic stress, and burnout) and posttraumatic growth among substance use helpers. This explanatory research design seeks to explain or describe the relationship among the variables (Cresswell, 2002). This correlational research will be guided by the tenets of positive psychology. Positive psychology is based in the idea that people can, and do, obtain positive change from experiencing adversity (Seligman & Csikszentimihalyi, 2000). This view provides a framework of understanding that allows for a study of optimism and strength (Seligman, 2002). Positive psychology has been applied to a variety of helping professionals which has resulted into research that investigates growth following adversity. Research has provided multiple constructs to describe positive change following adversity including resilience, compassion satisfaction, and posttraumatic growth all of which further give rise to foundational knowledge surrounding the human capacity to thrive (Bonanno, 2004; Werner, 1995; Stamm, 2010; Tedeschi & Calhoun, 1996). Compassion satisfaction (Stamm, 2010), Secondary traumatic stress (Figley, 1995), burnout (Maslach & Jackson, 1981), and posttraumatic growth (Tedeschi & Calhoun, 1996) are utilized in describing experiences of substance use helpers and the relationships between these constructs will be explored through a multiple regression analysis. Multiple regression analysis is most appropriate due to the nature of the research questions and will be further discussed in chapter 3.

Chapter Summary

The existing literature indicates that the population of substance use helpers exhibit high levels of turnover and negative experiences as a result of the work they do. In addition, substance use helpers as a profession sprung out of a highly stigmatized population of individuals seeking treatment as well as have a strong history and connection to the lay therapist movement.

Substance use helpers are exposed to unique challenges, adversity, and trauma in comparison to other populations of helping professionals and ranges in demographics such as educational level, experience, and recovery status. Although the research has begun to expand its examination of potential positive outcomes for helpers who work with high risk populations, such as compassion satisfaction, vicarious resilience, and vicarious posttraumatic growth, research on substance use helpers positive experiences as a result of their work is still limited and lacking in exploration into any connections between professional quality of life and posttraumatic growth. In addition to the lack of focus on substance use helpers, much of the existing body of literature on these positive outcomes is qualitative in nature and lacks empirical evidence.

This study will provide a quantitative look into the relationship between compassion satisfaction, secondary traumatic stress/compassion fatigue, and burnout with posttraumatic growth among substance use helpers. The study will shed light on potential correlations between professional quality of life and posttraumatic growth among this population of helpers and will fill the gap in the literature. In order to shift the focus away from pathological experiences of substance use helpers to more positivistic views, the study could have significant implications for the field as well as provide empirical evidence of the relationship between compassion satisfaction, secondary traumatic stress/compassion fatigue, and burnout with posttraumatic growth among this underrepresented population of helpers. The study could provide deeper

understandings of the relationship between professional quality of life and posttraumatic growth as well as provide suggestions for future study into positive dispositions of substance use helpers.

CHAPTER 3

Methodology

The purpose of this study was to explore if a relationship exists between a relationship exists between professional quality of life as well as personal and professional characteristics of substance use helpers and posttraumatic growth. This study used an exploratory survey-based research design to investigate substance use helpers experiences of subscales (burnout, secondary traumatic stress, and compassion satisfaction) of the Professional Quality of Life Scale V (Stamm, 2010) as they may relate to posttraumatic growth, as measured by the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996). The independent variables for this study was personal characteristics (education, experience, recovery status, level of care), compassion satisfaction as measured by the compassion satisfaction subscale of the ProQOL V, secondary traumatic stress, as measured by the secondary traumatic stress subscale of the ProQOL V, and burnout, as measured by the burnout subscale of the ProQOL V. The dependent variable was posttraumatic growth, as measured by the PTGI.

Research Questions/Hypothesis

The main questions to be addressed that were tested in this investigation are as follows:

1. How does substance use helpers compassion satisfaction, as measured by the Compassion Satisfaction subscale of the Professional Quality of Life Scale V (ProQOL V) (Stamm, 2010), relate to experiences of posttraumatic growth, as

- measured by the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996)?
2. How does substance use helpers secondary traumatic stress, as measured by the Secondary Traumatic Stress subscale of the ProQOL V (Stamm, 2010), relate to experiences of posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996)?
 3. How does substance use helpers' experiences of burnout, as measured by the Burnout subscale of the ProQOL V (Stamm, 2010), relate to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 1996)?
 4. How do substance use helpers' personal characteristics relate to experiences of posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996)?

To address each of the research questions the following hypothesis have been developed:

H₀1: Substance use helpers compassion satisfaction, as measured by the compassion satisfaction subscale of the Professional Quality Of Life 5 Scale (ProQOL 5) (Stamm, 2010), does not relate to posttraumatic growth, as measured by the PTGI (Tedeschi & Calhoun, 2010).

H₀2: Substance use helpers secondary traumatic stress, as measured the secondary traumatic stress subscale of the ProQOL 5 (Stamm, 2010) does not relate to posttraumatic growth, as measured by PTGI (Tedeschi & Calhoun, 1996).

H₀3: Substance use helpers' burnout, as measured by the burnout subscale of the ProQOL 5 (Stamm, 2010) does not relate to posttraumatic growth, as measured by PTGI (Tedeschi & Calhoun, 1996).

H₀4: Substance use helpers personal and/or professional characteristics (e.g. age, educational level, years of experience, recovery status) as defined in the demographic questionnaire, does not relate to posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996).

Research Procedures

This study used an exploratory survey-based research design to investigate if substance use helpers experiences of burnout, secondary traumatic stress, and compassion satisfaction relate to their experiences of posttraumatic growth. Burnout, Secondary Traumatic Stress, and Compassion satisfaction was be measured using the three subscales of the same name in the Professional Quality of Life Scale V (Stamm, 2010). Posttraumatic growth was measured using the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996). This quantitative inquiry was based on the concepts and assumptions coined by Maslow (1954) and expanded on by Seligman (2002) in the model of positive psychology.

Participant Selection

The participants for this study included substance use helpers who have had at least six months of providing direct clinical services to adults (individuals over the age of 18 years) in treatment for substance use disorder. Participants recruitment was done using both purposeful and snowball sampling in order to gain access to the target population of interest as well as increase the diversity of the sample. Recruitment flyers were sent electronically to substance use treatment centers of all levels (inpatient, outpatient, and private practices that identify substance use as an area of expertise). Treatment centers were found through an exhaustive internet search as well as a search of centers associated with addiction professional associations and websites.

Potential participants needed to meet certain inclusion criteria in order to gain access to the study. Inclusion criteria included potential participants being at least 18 years of age, a minimum of six months experience providing direct clinical services to individuals who have been diagnosed with substance use disorders and are currently providing direct clinical services to individuals diagnosed with substance use disorders.

Substance use treatment center directors were directly contacted via email and asked to forward a request for participation to all clinical employees. Recruitment letters for participation and recruitment flyers were also mailed through the postal service to drug and alcohol treatment facilities across the country and were asked that these documents be shared with clinical staff. In addition, requests for participation were also posted on counseling listserves and the recruitment flyer was posted on social media sites focused on substance use helpers in order to increase the diversity as well as meet the power analysis for sample size. Participants were incentivized with a chance to win one of two \$50.00 Amazon gift cards in a drawing which occurred at the end of the data collection phase of this study.

Instruments and Data Collection

Substance use helpers “personal characteristics” data was collected through the use of a demographic questionnaire which collected categorical data on participants demographics as well as items specific to the field of substance use treatment and the helping profession such as recovery status, quality of supervision, history of previous trauma. The demographic questionnaire also collected data on participants age, gender, ethnicity, education, licensure, years of experience, relationship status, spirituality, level of care they work in, and personal trauma history (Appendix A). Select items from the demographic questionnaire were chosen based on previous research regarding personal factors specific to substance use helpers as well as

relating to posttraumatic growth. Compassion satisfaction, secondary traumatic stress, and burnout was measured using the Professional Quality of Life Scale 5 (ProQOL 5) (Stamm, 2010). The ProQOL 5 is a 30 item self-report instrument which assesses both positive and negative experiences in regard to an individual's professional job as a helper. The ProQOL 5 consists of three subscales, compassion satisfaction, secondary traumatic stress, and burnout (Stamm, 2010). Posttraumatic growth was measured through the use of the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996). These instruments were chosen because the objective of this study was to determine if any relationship exists among compassion satisfaction and posttraumatic growth, secondary traumatic stress and posttraumatic growth, and burnout and posttraumatic growth among substance use disorders helpers.

Professional Quality of Life Scale V (ProQol 5)

The Professional Quality of Life Scale 5 (ProQol 5) is a self-report instrument which describes an individual's level of satisfaction in regard to their professional job as a helper (Stamm, 2010). The ProQOL 5 assesses a helping professional's quality of life both from a positive perspective as well as a negative perspective. The positive aspect of the ProQOL 5 is described as compassion satisfaction which is the enjoyment an individual gets from being able to do their job well (Stamm, 2010). The negative aspect of the ProQOL 5, compassion fatigue, is broken down into two separate parts, burnout and secondary traumatic stress. The first part of this is burnout which is described as feelings of exhaustion, frustration, anger, depression, hopelessness, and trouble coping with work or doing your job effectively (Figley, 1998; Stamm, 2010). The second dimension of the negative aspects the ProQOL 5 assesses is secondary traumatic stress. Secondary traumatic stress is "work-related, secondary exposure to others who have experienced extremely or traumatically stressful events" (Stamm, 2010). Compassion

satisfaction, burnout, and secondary traumatic stress make up the three subscales of the ProQOL 5.

Professional Quality of Life 5 Scale Reliability

The Professional Quality of Life Scale 5 (ProQOL 5) is a 30 item, self-report measure that utilizes a 5-point Likert scale ranging from 1= “Never” to 5= “Very Often”. It also utilizes reverse scoring of some items and scores are created by summing the items by subscale and then converting raw scores to t-scores (Stamm, 2010). Each subscale of the ProQOL 5 consists of 10 items using the 5-point Likert scale. Average scores for the Compassion Satisfaction subscale are 50 (SD 10; $\alpha = .88$). About 25% of individuals scoring higher than 57 and 25% score below 43. The higher range indicates experiencing a good deal of satisfaction from the work that an individual is doing while scores in the lower range (below 43) represent individuals who struggle to feel satisfied from their job and find difficulty or problems with their work (Stamm, 2010). Average scores for Burnout are 50 (SD = 10; $\alpha = .75$), roughly 25% of individuals score above a 57 and 25% score below 43 (Stamm, 2010). Scores below 18 indicate positive feelings regarding ability to do well at work whereas scores above 57 indicate feelings of inadequacy, hopelessness, and difficulties representative of burnout (Stamm, 2010). Average scores for Secondary Traumatic Stress are 50 (SD = 10; $\alpha = .81$) with an average of 25% of individuals score below 43 and roughly 25% score above 57 (Stamm, 2010). A score above a 57 would indicate a need to examine any feelings of fearfulness as higher scores are reflective of experiences of Secondary Traumatic Stress (Stamm, 2010).

Reliability alpha's for each of the subscales have been shown as follows Compassion Satisfaction subscale (10 items) reliability alpha of 0.88, Burnout subscale (10 items) with a reliability alpha of 0.75, and Secondary Traumatic Stress subscale (10 items) with a reliability

alpha of 0.81 (Stamm, 2010). In order to establish test-retest reliability Stamm (2002) used a sample of 374 trauma professionals, crisis workers, and debriefs which showed no significant difference in mean scores across time. The test-retest reliability showed compassion satisfaction ($\alpha = .87$; $M = 9.20$; $SD = 16.04$), burnout ($\alpha = .90$; $M = 24.18$; $SD = 10.78$), and secondary traumatic stress ($\alpha = .87$; $M = 28.78$; $SD = 13.15$) (Stamm, 2002).

Professional Quality of Life 5 Validity

According to Stamm (2010), the ProQOL V has been utilized in over 200 published papers, 100,000 articles on the internet, roughly 100 published peer-reviewed research papers which indicates good construct validity. The ProQOL has undergone multiple revisions with the current version of the ProQOL being the fifth revision. Revisions to the ProQOL have reduced multicollinearity between the Secondary Traumatic Stress and Burnout subscales (Stamm, 2010). Stamm (2010) reported that all three subscales are measuring different constructs with inter-scale correlations of 2%, shared variance ($r = -.23$; $\text{co-}\sigma = 5\%$; $n = 1187$) with Secondary Traumatic Stress and 5% shared variance ($r = -.14$; $\text{co-}\sigma = 2\%$; $n = 1187$) with Burnout. Burnout and Secondary Traumatic Stress showed shared variance of 34% ($r = .58$; $\text{co-}\sigma = 34\%$; $n = 1187$) which is explained in that the two subscales both reflect distress and unpleasant symptoms that are common among both constructs however Burnout does not address fears whereas Secondary Traumatic Stress does (Stamm, 2010).

Posttraumatic Growth Inventory (PTGI)

The Posttraumatic Growth Inventory (PTGI) was originally developed to explore how individuals, who have had to face the aftermath of experiencing a trauma, successfully reconstruct or strengthen their perceptions of self, others, and the meaning of events (Tedeschi and Calhoun, 1996). The PTGI is a 21 item, self-report, scale that uses a 6-point Likert scale,

ranging from 0= “I experienced this change to a very great degree as a result of my crisis” to 5= “I did not experience this change as a result of my crisis” (Tedeschi & Calhoun, 1996). The PTGI assesses overall positive experiences for individuals who have experienced traumatic/stressful life events and includes five subscales: (1) relations with others (7 items); (2) new possibilities (5 items); (3) personal strengths (4 items); (4) spiritual changes (2 items); and (5) appreciation of life (3 items) (Tedeschi & Calhoun, 1996). The Posttraumatic Growth Inventory has been used with a variety of populations and has been translated into multiple languages (Arnold et. al., 2005).

Posttraumatic Growth Inventory Reliability

The PTGI has shown good internal consistency (0.90) and acceptable test-retest reliability (0.71) (Tedeschi & Calhoun, 1996). Although the PTGI was originally developed to be used with individuals who had directly experienced a traumatic event there has also been some research that has utilized it to assess for vicarious experiences of posttraumatic growth (Abel et. al., 2014; Arnold et al., 2005; Beck, Rivera, & Gable, 2017; Brockhouse et al., 2011; Cosden et. al., 2016; Manning-Jones et. al., 2017). The previous literature that has utilized the PTGI as an assessment tool of helping professionals who had vicariously experienced traumatic events indicated Cronbach’s alphas ranging from 0.86 to 0.96 (Abel, Walker, Samios, & Morozow, 2014; Brockhouse, Msetfi, Cohen, & Joseph, 2011; Cosden, Sanford, Koch, & Lepore, 2016; Manning-Jones, de Terte, & Stephens, 2016; Tosone, Bauwens, & Glassman, 2016). Due to the previous research on the use of the PTGI to assess posttraumatic growth in helping professionals it was chosen to measure drug and alcohol helper’s experiences of posttraumatic growth in this study.

Posttraumatic Growth Inventory Validity

A review of the literature which examined individuals who had experienced perceived benefits as a result of trauma was used to generate 34 items that showed perceived changes of self, changes in sense of relationship with others, and changed philosophy of life (Tedeschi & Calhoun, 1996). In order to ensure validity Tedeschi & Calhoun (1996) compared individuals who had experienced trauma to those who had everyday life events. Three studies were conducted to develop the items and determine concurrent and discriminant validity as well as examine construct validity (Tedeschi & Calhoun, 1996). Results of these studies showed good internal validity with individuals who had reported experiencing trauma reporting significantly more benefits ($M=83.16$; $SD = 19.27$) compared to those who reported none ($M = 69.75$; $SD = 20.47$) ($F(1,113) = 12.33$, $p < 0.001$) (Tedeschi & Calhoun, 1996).

Procedures

Data collection began after approval from the Duquesne University Institutional Review Board. Participants were required to self-report data online through Qualtrics survey software. After obtaining informed consent via Qualtrics, which hosted an inclusion qualifying questionnaire, a brief demographic questionnaire, as well as the Professional Quality of Life Scale V (Stamm, 2010), and the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996). The first measure to be completed was the Professional Quality of Life Scale 5 (ProQol 5) (Stamm, 2010). This measure was used to collect data on substance use helpers' experiences of burnout, secondary traumatic stress, and compassion satisfaction. The Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996), was used to collect data on substance use helpers' experiences of posttraumatic growth and was completed after the ProQOL 5.

This information was used to determine if there is any relationship between burnout, secondary traumatic stress, compassion satisfaction and posttraumatic growth among drug and

alcohol helpers. The second measure that was completed was the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996). The PTGI provided insight into the phenomena of posttraumatic growth experienced among drug and alcohol helpers and was used to assess for any relationship between burnout, secondary traumatic stress, compassion satisfaction and posttraumatic growth among drug and alcohol helpers.

Data Analysis

Sample size was determined using G*Power analysis and was compared to G*Power analysis to determine if the sample had enough power to complete recruitment and begin data analysis. Once it had been determined that power had been met, all data collected was input into SPSS for data analysis. The dependent variable was identified as total scores on the Posttraumatic Growth Inventory and the independent variables were identified as scores on the compassion satisfaction subscale of the Professional Quality of Life Scale 5 (ProQOL 5), scores on the secondary traumatic stress subscale of the ProQOL 5 and scores on the burnout subscale of the ProQOL 5. Additionally, the independent variable of substance use helpers' personal and professional characteristics was determined using self-reported categorical responses on the demographic questionnaire. Statistical analysis of the data included a multiple regression analysis which was conducted in the Statistical Package for the Social Science version 25 software (SPSS) to determine correlations and test the research hypothesis.

Checks were made to ensure that all assumptions were met prior to conducting the analysis, including linear relationship, multivariate normality, multicollinearity, and homoscedasticity were met (Field, 2014). The linear relationship assumptions were examined through the use of scatterplots which indicated if there was a linear or curvilinear relationship (Field, 2014). The assumption of normality was checked with a goodness of fit test (Field,

2014). The third assumption that there is no multicollinearity in the data was checked through a computation of a matrix of Pearson's bivariate correlations among all independent variables, a variance of inflation factor (VIF) analysis was also conducted (Field, 2014). Lastly the assumption of homoscedasticity was addressed by creating a scatterplot of residuals versus predicted values (Field, 2014). These checks to assumptions of the data are discussed to provide evidence that the appropriate analysis was conducted during this phase of the study and any transformations or fixes will be further discussed in detail.

Human Participants and Ethical Precautions

This study complied with Duquesne University's Institutional Review Board (IRB) for the protection of the human subjects involved in all forms of research. Prior to any participant recruitment or data collection IRB approval was granted. Following IRB approval, participants of the study were given a link to the online version of the survey via emails, recruitment flyer, and/or recruitment letter. The link provided participants with the opportunity to read the online informed consent and agree to the conditions of the study prior to beginning any data collection. Participants were informed that there would be minimum risk, no greater than those faced in everyday life. Participants were informed that responses would be kept confidential. Participants were also informed that they are under no obligation to participate in the study, and consent can be revoked at any time.

Confidentiality was maintained throughout the study, using several means to protect the information provided by study participants. Informed consent was obtained prior to study participation. Only the researcher had access to study scores and no identifying information was collected due to the anonymous nature of the data collection process. The researcher was the only one to view scores from the measures used and again no identifying information was

collected due to the anonymous nature of data collection through Qualtrics. When manually entering the data into SPSS, data was coded, and no identifiers were used. Results were not presented in a manner that would reveal any identifying information of any individual in the study. Data analysis and storage was done on the researcher's password protected computer and all data was destroyed at the conclusion of the study.

Chapter Summary

This chapter presented a description of the sample and data collection procedures as well as instruments used to gather data in this research. In addition to providing a description of the sampling and data collection procedures, this chapter also outlined the statistical analysis and methods used to develop this research. Data from this research was collected anonymously using Qualtrics online survey software. Instruments used to collect data included a demographic questionnaire, the Professional Quality of Life Scale 5, and the Posttraumatic Growth Inventory. The sample was primarily recruited using online platforms by posting recruitment flyers on social media sites with groups specific to substance use helping professionals. Recruitment also included posting requests to listservs and emailing the recruitment flyer to clinical directors of substance use treatment facilities across the United States. Participants were incentivized with the chance to win one of two \$50.00 Amazon gift cards. In order to accomplish the aims of the study a multiple linear regression analysis was performed. Results of the analysis are provided in the next chapter (Chapter 4).

CHAPTER 4

Results

According to the Substance Abuse and Mental Health Service Administration the need for substance use helping professionals continues to grow into crisis levels (Hyde, 2013).

Additionally, previous research has shown that annual staff turnover rates for substance use disorder treatment facilities have been reported to range between 19% to 50% (Eby, Burk, & Maher, 2010; McNulty et. al., 2007; White & Garner, 2011). Despite this need, research into the impact of working in the field of substance use disorder treatment have largely focused on negative experiences and pathology of helping professionals employed in this field (Bergman, Kelly, Nargiso, & McKowen, 2016; Ericson, 2001; Scott & Patterson, 2003; Perkins & Sprang, 2013; Pullen & Oser, 2014; White, 1998). More recently a growing body of literature has begun to investigate the potential for benefits to the helping professional as a result of working with difficult client populations (Abel et. al., 2014; Arnold et. al., 2005; Cohen & Collens, 2013; Cosden et. al., 2016; Hyatt-Burkhart, 2014; Linley & Joseph, 2006). Although previous research has begun to investigate the benefits of working with difficult populations few have focused on experiences of helping professionals working in the field of substance use disorder.

The purpose of this study was to explore the relationship between posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI), and professional quality of life, as

measured by the Professional Quality of Life Scale 5 (ProQOL 5), compassion satisfaction, secondary traumatic stress, and burnout, among substance use disorder helpers. In addition, the study also examined the relationship between posttraumatic growth, as measured by the PTGI, and personal characteristics, collected from the demographic questionnaire, of substance use disorder helpers. Participants for this study were recruited through electronic requests to clinical directors of substance use disorder treatment facilities across the United States of America. Additionally, requests were posted online via substance use disorder helping professional online professional groups, listservs, and social media through purposeful and snowball sampling methods. All data was collected anonymously through the use of Qualtrics online survey software. Once data collection was completed the data was downloaded from the Qualtrics platform and input into the Statistical Package for Social Sciences (SPSS) version 25 for data cleaning and analysis. The results of the statistical data and analysis are presented in this chapter.

Survey Data

Initial Data Screening

Data were screened, and cases were eliminated if the participants did not complete all three survey sections (Demographic Questionnaire, Professional Quality of Life Scale 5, and the Posttraumatic Growth Inventory). Missing values in categorical data did not interfere with the analysis and were not modified. Missing values for other data were replaced using the Series Mean method. A preliminary multiple regression analysis was run to check for assumptions and outliers. Outliers were identified using Mahalanobis distance and Chi Squared critical values. Data screening and analysis was completed using the Statistical Package for Social Sciences (SPSS) 25.00 software application.

Research Questions

1. How does substance use helpers' compassion satisfaction, as measured by the Compassion Satisfaction subscale of the Professional Quality of Life Scale V (ProQOL V), relate to experiences of posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI)?
2. How does substance use helpers' secondary traumatic stress, as measured by the Secondary Traumatic Stress subscale of the ProQOL V, relate to experiences of posttraumatic growth, as measured by the PTGI?
3. How does substance use helpers' experiences of burnout, as measured by the Burnout subscale of the ProQOL V, relate to posttraumatic growth, as measured by the PTGI?
4. How do personal characteristics of substance use helpers' contribute to experiences of posttraumatic growth, as measured by the PTGI?

Demographic Information

Participants in this study included individuals who had a minimum of a high school diploma/GED, were at least 18 years old, were currently working as substance use disorder helpers, and had been doing so for a minimum of 6 months. A total of 183 individuals consented to participate in this study. After the initial data screening, 168 cases had met all inclusion criteria and were utilized in the analysis. Of the respondents 65.5% were female and 34.5% were male. The two largest represented age groups were ages 25-34 (32.1%) and ages 35-44 (30.4%). Caucasian was the largest ethnicity represented 89.9%. Other ethnicity groups in the sample included African Americans 5.4%, Asian 1.8% and Hispanic or Latino 3.%. A majority of the respondents were married 55.4% with the second largest group of respondents reporting single 21.4%, followed by those identifying as in a long-term committed relationship 13.1%. A majority of the respondents 43.9% had between 0-5 years of experience while 20.5% had between 5.1-10

years of experience. In addition, respondents reported licensure or certification status, 33.9% of respondents identified as having multiple licensure and/or certification, 22% Certified Addiction Counselors, 22% did not hold any licensure or certifications, 14.3% Licensed Professional Counselor, and 6.5% National Certified Counselor.

In regard to respondents' perceptions of the quality of supervision of supervision they received, respondents rated the two largest groups as "very good" (32.7%) and "good" (25%). A majority of respondents worked in outpatient settings 48.8%, while the second largest group worked in a short-term residential setting 35.7%. Concerning the respondents of this sample populations own personal history of trauma, 58.9% identified as having experienced a personal trauma and 41.1% had not experienced a personal trauma. The descriptive statistics (mean, standard deviation, measures of central tendency) were analyzed using a frequency distribution in the Statistical Package for the Social Sciences (SPSS) version 25. The demographic information (gender, age, ethnicity, relationship status, licensure, quality of supervision, level of care, years' of experience, and trauma history) is presented in table 4.1 and table 4.2.

Table 4.1

Demographic Information

Variables	Percent of Participants	Mean	Standard Deviation
Gender		1.65	.48
Male	34.5		
Female	65.5		
Age		3.24	1.31
18-24	3		
25-34	32.1		
35-44	30.4		
45-54	13.7		
55-65	13.7		
65& older	7.1		
Ethnicity		5.62	1.22
African American	5.4		

Asian	1.8		
Hispanic or Latino	3		
Caucasian	89.9		
Relationship Status		2.17	.99
Single	21.4		
Long-term committed relationship	13.1		
Married	55.4		
Divorced	6.5		
Widowed	2.4		
Other	1.2		
Trauma History		1.41	.49
I have experienced personal trauma	58.9		
I have not experienced personal trauma	41.1		

N=168

Demographic information was also collected on additional personal characteristics of participants including some characteristics more specific to substance use helping professionals such as how they may identify in terms of their own personal recovery status (in recovery from an addiction, abstinent, or do not identify as a recovering from a substance use disorder) through completion of a demographic questionnaire. Participants were asked to provide information on the highest level of education they had completed (Education), if they themselves identified as being in recovery from a substance use disorder (Recovering Status), opinions on the quality of clinical supervision they received (Supervision), how many years of experience they had been working in the field (Years' Experience), if they had any type of counseling license or certification (Licensure), and at what level of care they were provided clinical services (Level Of Care). The Recovery status question on the demographic questionnaire asked participants to choose one of three options "I am abstinent from drugs and alcohol", "I am recovering or in a 12-step program for drugs and/or alcohol", or "I do not identify as having a substance use

disorder”. The second part of the demographic information of the respondents are presented in table 4.2.

Table 4.2

Demographic Information Cont.

Variable	Percent of Participants	Mean	Standard Deviation
Education		2.78	.67
High School/GED	5.4		
Bachelor’s Degree	19.8		
Master’s Degree	66.1		
PhD	8.3		
Recovery Status		1.18	.63
Abstinent	12.5		
Recovery/12-Step	31		
None	56.5		
Supervision		2.55	1.20
Excellent	20.8		
Very Good	32.7		
Good	25		
Fair	13.7		
Poor	7.1		
Very Poor	0.6		
Years’ Experience		1.27	1.47
0-5yrs	44.6		
5.1-10yrs	21.4		
10.1-15yrs	12.5		
15.1-20yrs	5.4		
Over 20 yrs	16.0		
Licensure Status		3.28	1.46
Certified Addiction Counselor	22		
National Certified Counselor	6.5		
Licensed Professional Counselor	14.3		
Multiple Licensure/Certificates	33.9		

None	22		
Level Of Care		2.42	.75
Long-term residential	12.5		
Short-term residential	35.7		
Outpatient	48.8		
Private Practice	3		

N=168

Posttraumatic Growth Inventory

The Posttraumatic Growth Inventory is a 21-item scale that uses a 6-point Likert scale, ranging from 0= “I experienced this change to a very great degree” to 5 = “I did not experience this change as a result of my crisis”. The scale was originally developed to explore how individuals, who have experienced traumatic events, successfully recreate and/or improve their perceptions of self, others, and the meaning of the traumatic event (Tedeschi & Calhoun, 1996). The measure has also been used to assess for vicarious experiences of posttraumatic growth. Cronbach’s alpha for other groups of helping professionals has ranged from 0.86-0.96 (Abel et al., 2014; Brockhouse et al., 2011; Cosden et al., 2016; Manning-Jones et al., 2016; Tosone et al., 2016). After receiving permissions from the PTGI authors the prompt was changed from “as a result of my trauma...” to “as a result of my work with substance use disorder...”. Scores are calculated by totaling the responses. Some have suggested when totaling the score, defining scores below 45 as none to low, and scores above 46 as moderate to high levels of posttraumatic growth (Holtmaat, van der Spek, Cuijpers, Leemans, & Verdonck-de Leeuw, 2017) or by grouping mean scores with the cut off score as 3 (Jansen, Hoffmeister, Change-Claude, Brenner, & Arndt, 2011). Tedeschi & Calhoun do not note a cut off for significance in scoring but rather state that the higher the total score, the more growth that individual has experienced.

Descriptive statistics for the 21-item Posttraumatic Growth Inventory are presented in Table 4.3. The mean score for this sample was 55.42 with a standard deviation of 23.79. The composite score for the inventory ranges from 0-105, with higher scores representing a higher level of growth. The composite scores for this study sample ranged from 0-105. Item 2 (appreciation of life), item 10 (personal strength), item 13 (appreciation of life), and item 15 (relating to others) had the highest mean scores ranging from 3.04-3.28. Item 18 (spiritual change) had the lowest mean score (1.67). The reliability of the Posttraumatic Growth Inventory was determined by using Cronbach's Alpha Coefficient. The reliability for the Posttraumatic Growth Inventory for this study was 0.95.

Table 4.3

Descriptive Statistics for the Posttraumatic Growth Inventory

Item*	Mean	SD	Range
1. I changed my priorities about what is important in life	2.45	1.38	0-5
2. I have a greater appreciation for the value of my own life	3.28	1.42	0-5
3. I have developed new interests	2.21	1.51	0-5
4. I have greater feeling of self-reliance	2.82	1.48	0-5
5. I have a better understanding of spiritual matters	2.78	1.68	0-5
6. I more clearly see that I can count on people in times of trouble	2.44	1.67	0-5
7. I established a new path for my life.	2.29	1.71	0-5
8. I have a greater sense of closeness with others	2.43	1.53	0-5
9. I am more willing to express my emotions	2.51	1.54	0-5
10. I know better that I can handle difficulties	3.04	1.48	0-5
11. I am able to do better things with my life.	2.64	1.67	0-5

12. I am better able to accept the way things work out.	2.85	1.56	0-5
13. I can better appreciate each day.	3.04	1.52	0-5
14. New opportunities are available which wouldn't have been otherwise.	2.76	1.69	0-5
15. I have more compassion for others.	3.07	1.51	0-5
16. I put more effort into my relationships	2.55	1.47	0-5
17. I am more likely to try to change things which need changing.	2.82	1.45	0-5
18. I have a stronger religious faith	1.66	1.65	0-5
19. I discovered that I'm stronger than I thought I was.	2.95	1.50	0-5
20. I learned a great deal about how wonderful people are.	2.81	1.56	0-5
21. I better accept needing others.	2.42	1.57	0-5
Total Score	55.63	23.89	0-105

*The higher the mean, the greater the level of posttraumatic growth

Professional Quality of Life Scale

The Professional Quality of Life Scale V (ProQOL V) is a 30-item, 5-point likert scale, ranging from 1= “Never” to 5= “Very Often”. The ProQOL V is commonly used to measure both positive and negative impacts of professional life and yields scores for three subscales, Compassion Satisfaction (10 items), Burnout (10 items), and Secondary Traumatic Stress (10 items) (Stamm, 2010). Stamm (2010) notes that the ProQOL is one of the most commonly used measures and has been shown to report good psychometric properties. Each subscale is summed to provide a total for that subscale (i.e. the sum of secondary traumatic stress score equals 22). Threshold scores for the ProQOL V are designated as “Low” (sum of scores equals 22 or less), “Average” (sum of subscale scores equals between 23-41), and “High” (sum of subscale score equals 42 or more) (Stamm, 2010).

Descriptive statistics for the Professional Quality of Life Scale Subscales are presented in Tables 6. Each subscale is assessed independently of the other subscales. The composite score for the Compassion Satisfaction Subscale ranges from 10-50 with a higher score representing higher levels of compassion satisfaction. The mean composite score for the sample was 41.44 (S.D.= 4.91). The reliability of the Compassion Satisfaction Subscale with this sample was determined by using Cronbach's Alpha Coefficient. The reliability for the Compassion Satisfaction Subscale for this study was 0.86. Composite scores for Burnout Subscale ranges from 10-50 with higher scores representing higher levels of burnout. The mean composite score for the sample was 20.39 (S.D.= 4.72). Reliability of the Burnout Subscale with this sample was determined by using Cronbach's Alpha which was 0.76. Composite scores for the Secondary Traumatic Stress Subscale range from 10-50 with higher scores representing higher levels of secondary traumatic stress. The mean composite score for the sample was 18.91 (S.D.= 4.45). Reliability of the Secondary Traumatic Stress Subscale for this sample was determined using Cronbach's Alpha which was 0.74.

Table 4.4.

Descriptive Statistics and Reliability for ProQOL V Subscales

ProQOL V Subscale	Mean	S.D.	Cronbach's Alpha
Compassion Satisfaction	41.44	4.91	0.86
Burnout	20.39	4.72	0.76
Secondary Traumatic Stress	18.91	4.45	0.74

This study included four research hypothesis investigating relationships between professional quality of life (compassion satisfaction, burnout, secondary traumatic stress),

personal characteristics, and posttraumatic growth among substance use helping professionals. The results were analyzed with the Statistical Package for Social Sciences software version 25.0. The first research question inquired about the relationship between compassion satisfaction and posttraumatic growth among substance use disorder helpers. The second research question inquired about the relationship between secondary traumatic stress and posttraumatic growth among substance use helpers. The third research question inquired about the relationship between burnout and posttraumatic growth among substance use helpers, and the fourth research question inquired about the relationship between substance use helpers personal characteristics (educational level, gender, and recovery status) and posttraumatic growth. A hierarchical linear regression analysis was used to examine the research questions. Cronbach's alpha analysis was run prior to data analysis to ensure reliability using the PTGI with this sample population. The posttraumatic growth inventory was found to be highly reliable (21 items; $\alpha=0.95$).

Correlational Analysis

A correlational analysis was run to evaluate the strength of the associations between compassion satisfaction, burnout, and secondary traumatic stress (as measured by the three subscales of the ProQOL V), personal characteristics (age, gender, ethnicity, years of experience, quality of supervision, level of care, educational level, recovery status, trauma history), and posttraumatic growth (as measured by the PTGI). Relationship between the independent variables (personal characteristics, compassion satisfaction, secondary traumatic stress, and burnout), and dependent variable (scores on the PTGI) were determined using corresponding scores from the variables and tested through the same Pearson product moment correlation coefficient statistic.

For this analysis correlations were found between (IV) demographic variables, subscales of ProQOL V, and the (DV) scores on the PTGI. The correlation between demographic variables (age, gender, education, recovery status, quality of supervision, and years of experience) and the (DV) scores on the PTGI were weak however they did present as statistically significant (Table 4.5). The correlation between the three subscales of ProQOL V and scores on the PTGI were also weak and only secondary traumatic stress and compassion satisfaction presented as statistically significant. Additionally, correlations between independent variables were also identified through this correlational analysis. All correlations are presented in Table 4.5.

Table 4.5
Correlations

	1	2	3	4	5	6	7	8	9	10
1. Gender	1									
2. Trauma Hx	.021	1								
3.Recovery	-.164*	-.186*	1							
4.Education	-.062	-.053	.086	1						
5. Years Experience	-.234**	-.062	.132	.086	1					
6. LOC	-.049	.031	-.039	.247**	.054	1				
7. C.S.	-.024	-.132	-.026	-.071	.036	.194*	1			
8. Burnout	.054	.025	-.089	-.015	-.148	-.174*	-.660**	1		
9. STS	.137	-.133	.072	-.046	-.082	-.078	-.155*	.540**	1	
10. PTG	-.170*	-.088	.062	-.186*	-.067	-.040	.379**	-.167*	.135	1

* $p < 0.05$ (2-tailed); ** $p < 0.001$ (2-tailed)

Examination of Model Assumptions

The next step in this analysis involved testing of assumptions. Shapiro-Wilk test of normality was run to test if the sample comes from a normal distribution. This test was

conducted to examine the assumption of normality of the model being used. The Shapiro-Wilk test of normality showed non-significance ($p > 0.05$) which indicated that the dependent variable met the test of normality (Table 4.6).

Table 4.6
Test of Normality

	Kolmogorov-Smirnov			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PTGI	.062	171	.200	.984	171	.051

A preliminary regression analysis was also conducted to check the assumptions of Linearity, normality, and homoscedasticity and were assessed using normal *P-P* plot, and scatterplots. Multicollinearity was also assessed using correlation tables and through examination of the Tolerance and VIF scores (Table 4.7).

Table 4.7
Multicollinearity testing

Variable	Tolerance	VIF
Compassion Satisfaction	.467	2.14
Secondary Traumatic Stress	.587	1.70
Burnout	.337	2.96
Recovery	.922	1.08
Educational Level	.924	1.08
Years of Experience	.929	1.07
Trauma	.963	1.04

Level of Care	.929	1.07
Gender	.924	1.08

Regression Analysis

A hierarchical multiple linear regression analysis was conducted to analyze data in order to answer the research questions. Hierarchical regression is used to evaluate the relationship between a set of independent variables and a dependent variable, controlling for the impact of a different set of independent variables on the dependent variable. In hierarchical regression independent variables are entered into the analysis in a sequence of blocks, or groups containing one or more variables (Field, 2013). In the first block, demographic variables were entered in order to control for the potential impact on the results as well as to explore correlation between substance use helpers personal characteristics and scores on the Posttraumatic Growth Inventory (PTGI). The independent variables recovery status, educational level, years of experience, history of personal trauma, level of care in which the helpers were providing clinical services, and gender as well as the dependent variable posttraumatic growth (scores on the PTGI) were all entered into the first block. These were chosen as personal characteristics to be included in the analysis as they have been discussed in the professional literature as personal characteristics that are unique to substance use helping professionals. Additionally, some personal characteristics such as gender and personal history of trauma were also included due to previous research on correlations between these variables and posttraumatic growth. Scores on the PTGI (dependent variable) and the three subscales of the ProQOL V (compassion satisfaction, secondary traumatic stress, and burnout) were entered into the second block.

Research Hypothesis

The following hypothesis were analyzed in this study:

Research hypothesis 1. Substance use helpers scores on the compassion satisfaction subscale of the Professional Quality Of Life Scale V (ProQOL V), is not predictive of experiences of posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI).

Research Hypothesis 2. Substance use helpers scores on secondary traumatic stress subscale of the ProQOLV is not predictive of experiences of posttraumatic growth as measured by the PTGI.

Research Hypothesis 3. Substance use helpers scores on the burnout subscale of the ProQOL V, is not predictive of posttraumatic growth as measured by the PTGI.

Research Hypothesis 4. Substance use helpers' personal characteristics (recovery status, educational level, level of care, trauma history, and years' experience) are not predictive of posttraumatic growth (as measured by scores on the PTGI).

Scores on the Posttraumatic Growth Inventory was the dependent variable for this two-step hierarchical regression analysis. Recovery status, educational level, level of care, trauma history, years' experience, and gender were identified as personal characteristics and were entered in step one. These personal characteristics accounted for 8.8% of the variance in posttraumatic growth (dependent variable). The three independent variables (compassion satisfaction, secondary traumatic stress, and burnout) were entered in step two. The addition of the three subscales of the ProQOL V (compassion satisfaction, secondary traumatic stress, and burnout) the model as a whole explained 25.8% of the variance in the dependent variable. The addition of the three subscales explained an additional 17%. Examination of the Standardized Coefficient (Beta values) and Significance revealed some personal characteristics to be statistically significant in the first model including "Gender" and "Education". The second model

revealed compassion satisfaction, and secondary traumatic stress as statistically significant at $p < 0.05$. The regression statistics are presented in Table 4.8 for each of the two steps.

Table 4.8

Summary of Hierarchical Regression Analysis

Posttraumatic Growth Inventory Scores				
Variable	Model 1		Model 2	
	B	Beta	B	Beta
Constant	85.48		-5.60	
Recovery	1.02	.030	.942	.027
Gender	-9.61	-.207	-10.44	-.228
Trauma History	-3.88	-.088	-.119	-.003
Education	-7.78	-.197	-5.38	-.137
Years of Experience	-1.48	-.100	-1.54	-.104
Level of Care	-.085	-.025	-3.64	-.083
CS			1.72	.386
Burnout			-.205	-.044
STS			1.08	.220

R^2	.088	.258
F	2.59	6.07
ΔR^2	.088	.170
ΔF	2.59	11.96

The hierarchical multiple regression analysis revealed that the predictor variables recovery status, trauma history, education, years of experience, level of care, and gender (step-one) accounted for 8.8% of the variance in PTGI scores and was statistically significant, $R^2=0.088$, $F(6,166)=2.59$, $p<0.05$. Addition of the three subscales of the ProQOL V (compassion satisfaction, burnout, secondary traumatic stress) accounted for an additional 17% of the variance in posttraumatic growth scores on the PTGI and was also statistically significant, $R^2=0.258$, $F(9,166)=6.07$, $p<0.001$. The independent variables for both step one and step two accounted for 25.8% of the variance in posttraumatic growth (as measured by scores on the PTGI).

Chapter Summary

This chapter provided a description of substance use disorder helpers sample populations' compassion satisfaction, burnout, secondary traumatic stress, and personal characteristics. Compassion satisfaction, burnout, and secondary traumatic growth were collected from scores on the subscales of the Professional Quality of Life Scale V (ProQOL V). Personal characteristic data was obtained through a demographic questionnaire. Substance use helpers' posttraumatic growth (dependent variable) was measured by the Posttraumatic Growth Inventory. The data revealed a statistically significant relationship between compassion satisfaction, secondary

traumatic stress, and burnout (scores on the subscales of the ProQOL V) and posttraumatic growth (scores on the PTGI), leading to the rejection of hypothesis one, two, and three. Additionally, step one in the data analysis showed that substance use helpers' personal characteristics (gender, trauma history, recovery status, educational level, years of experience, and level of care) and posttraumatic growth (scores on the PTGI) also showed statistical significance, leading to the rejection of hypothesis four. Although step one of the analysis (personal characteristics) was statistically significant further investigation into specific categorical variables showed not all were statistically significantly correlated to scores on the posttraumatic growth inventory.

The hierarchical multiple regression analysis was used to determine the variables which were predictive of substance use helpers' posttraumatic growth, as measured by scores on the PTGI. Compassion satisfaction was statistically significant in predicting a substance use helpers' posttraumatic growth (scores on the PTGI) ($\beta = 0.386, p < 0.001$) and was also the highest predictor of scores on the PTGI. Secondary traumatic stress was also statistically significant in predicting substance use helpers scores on the PTGI ($\beta = .220; p < 0.05$). In regard to substance use helpers' personal characteristics upon further investigation only two specific categorical variables of personal characteristics were statistically significant. Education ($\beta = -.197; p < .05$) and gender ($\beta = -.207; p < .01$), were the only two categorical variables within the personal characteristics step of the analysis found to provide statistical significance in predicting scores on the PTGI. There was no statistically significant relationship found between burnout and posttraumatic growth ($\beta = -.044$), recovery and posttraumatic growth ($\beta = .030$), trauma history and posttraumatic growth ($\beta = -.088$), years of experience and posttraumatic growth ($\beta = -.100$), or level of care and posttraumatic growth ($\beta = -.002$). In summary, professional

quality of life (compassion satisfaction, burnout, and secondary traumatic stress as measured by the three subscales of ProQOL V), and personal characteristics of substance use helpers (recovery status, trauma history, years of experience, level of care, gender, and education) account for 25.8% of the variance of substance use helpers' posttraumatic growth (as measured by the PTGI). Further investigation into specific variables correlations to posttraumatic growth (as measured by the PTGI)

Chapter 5

DISCUSSION AND RESULTS

Substance use helpers encounter a plethora of experiences as a result of the work they do; however their work has largely been primarily viewed through a lens of negativity in the past with a focus on the high risk, potentially deleterious aspects of working with individuals who have a substance use disorder (Baldwin-White, 2016; Eby, Burk, & Maher, 2010; Oser, Biebal, Pullen, & Harp, 2013; Young, 2015). Individuals with substance use disorders have a tremendous capability to move beyond some of the most horrific traumas and setbacks in life and yet there has been little research into how those who work with this population may be positively impacted by the work they do. The purpose of this study was to determine if any correlation exist among substance use helpers compassion satisfaction, secondary traumatic stress, and burnout, as measured by the subscales of the Professional Quality Of Life Scale (ProQOL V), personal characteristics and posttraumatic growth, as measured by the Posttraumatic Growth Inventory (PTGI) among this specific population of helping professionals.

Summary of the Study

This study utilized a correlational, exploratory research design to investigate whether compassion satisfaction, secondary traumatic stress, and burnout (as measured by the subscales

of the ProQOL V) play a role in substance use helpers experiences of posttraumatic growth, as measured by the PTGI. This study also sought to delve into substance use helpers' personal characteristics and examine if specific characteristics play a role in promoting posttraumatic growth, as measured by the PTGI. This quantitative correlational study was based on the concepts and assumptions first proposed by Martin Selgiman (2002) and positive psychology that were expanded upon by Tedeschi and Calhoun (1996) with their model of posttraumatic growth. Participants for this study were recruited through the research investigators use of purposeful and snowball sampling methods by sending secured emails to clinical directors of addiction treatment centers, flyers, addiction professional listserv, and addiction professional social media groups.

The target population for this study included substance use helpers who have at least a high school diploma or GED, are providing direct counseling services to individuals diagnosed with a substance use disorder, have been providing direct counseling services to individuals with substance use disorder for a minimum of 6-months, and are at least 18 years old or older. Substance use disorder treatment facilities across the United States were contacted via recruitment emails to clinical managers and supervisors. Recruitment flyers were also posted on social medial groups that were open to anyone from the United States who was actively practicing as a substance use disorder helping professional. Due to the geographic and anonymous nature of the study it is not known exactly how many individuals composed the population of recruitment however 183 individuals meet criteria to be included in the study. Of the 183 substance use helpers enrolled in the study, 168 (92%) completed all the sections of the surveys.

Major Findings

Research Question #1

The first research question investigated whether compassion satisfaction, as measured by the compassion satisfaction subscale of the ProQOL V, contributed to posttraumatic growth, as measured by the PTGI. The research hypothesis was that compassion satisfaction, as measured by the compassion satisfaction subscale of the ProQOL V, would not be predictive of posttraumatic growth, as measured by the PTGI among substance use helpers. Results indicated that scores on the compassion satisfaction subscale of the ProQOL V did correlated significantly with scores on the PTGI. The results of this study provided empirical evidence that substance use helpers compassion satisfaction significantly, positively, related to posttraumatic growth. Positive relationships between compassion satisfaction and posttraumatic growth have been found in other studies with other populations of helping professionals (Hunter, 2012; Hyatt-Burkhart, 2014; Kjellenberg, Nilsson, Daukantaite, & Cardena, 2014).

This result provides quantitative evidence that substance use helpers responses are in line with previous research and is in line with previous research with other populations of helping professionals. Very little research has been done to investigate the experience of compassion satisfaction with substance use helpers and even less have investigated how this construct may relate in a different way to posttraumatic growth among this population of helping professions. These results indicate that substance use helpers respond and experience compassion satisfaction in a similar way as other helping professionals. The results of this study also provide further empirical evidence of the relationship between compassion satisfaction and posttraumatic growth. These results provide an opening to further be explored. Although some such as Perkins & Sprang (2013), have investigated professional quality of life with substance abuse counselors, previous research has paid little attention to the role of compassion satisfaction and its

relationship to posttraumatic growth. These results validate previous research and further provide empirical evidence to support the construct of posttraumatic growth.

These results further elucidate the gaps in the professional body of knowledge and provide further evidence that there is a continued need for research on both compassion satisfaction and posttraumatic growth among substance use helpers. Variables such as years of clinical experience, amount and quality of supervision, knowledge of the constructs, level of care that individuals are practicing from are all areas that would benefit from continued research. Operational definitions of compassion satisfaction and posttraumatic growth continue to need further delineation to allow for illumination of the differences between these two constructs as well as continued exploration of the relationship between them.

Research Question #2

The second research question, the level of burnout (as measured by the burnout subscale of the ProQOL V) of substance use helpers was measured and compared to posttraumatic growth (as measured by the PTGI). There have been multiple studies with other populations of helping professionals (nurses, social workers, physicians, mental health counselors) that have observed negative relationships between burnout and posttraumatic growth as well as explored the potential mediating effect of posttraumatic growth on rates of burnout (Beck, Eaton, & Grable, 2016; Chang, 2014; Taku, 2014; Ying, Wang, Lin, & Chen, 2016).

Few investigations have examined the relationship between burnout and posttraumatic growth with substance use helping professionals. Although few have explored relationships between burnout and posttraumatic growth with substance use helpers', there has been a vast body of research that has explored the construct of burnout within the population of substance use helping professionals. Previous research has identified specific variables that may be unique

to the substance use helping profession, and that may contribute to experiences of burnout including low wages, limited training and education, high volume of client trauma's and mortalities, high recidivism rates, and limited clinical supervision (Ogborne, Braun, & Schmidt, 1998; Oser, Biebel, Pullen, & Harp, 2013; Vilardaga, Luoma, Hayes, Pistorello, Levin, Hildebrandt, & Bond, 2011). This adds to the demographic makeup of the population of substance use helping professionals as well as the importance of examining their experiences of burnout and posttraumatic growth. There was not a significant relationship between burnout and posttraumatic growth in this study. The sample of this study had a mean score of 20.05 indicating that the overall sample on average reported low levels of burnout (Stamm, 2010).

The sample demographics may have impacted their lowered levels of overall burnout in comparison to previous research. The sample was primarily employed at an outpatient level of care which may have reduced their exposure to varying levels of severity regarding client trauma. The sample population of substance abuse helpers also come from all across the United States of American and the analysis run did not account for cultural differences, primary method of treatment (abstinence based, 12 Step, Cognitive Behavioral, Medication Assisted, etc) which could impact levels of burnout that may have been experienced. In addition, the level of burnout reported in this study could not have been at a high enough level to impact the study results. Other demographic factors such as age, educational level, and marital status could have also impacted the outcome. It may be that substance use workers who are 25-34 years old (M=32.2%), hold a master's degree (65.5%), and are married (55.6%) may have developed self-care strategies to cope with work place stressors that lead to burnout. It is also possible that those who experience burnout frequently change jobs or leave the field. With the sample demographics being middle aged and having worked in the field for a minimum of 6- months

with the majority of the sample employed between 0-5 years (43.9%), this sample may not have captured higher levels of burnout.

Burnout is also a construct that is not unique to engagement in a therapeutic relationship, anyone from any profession could experience burnout. Thus, experiences of burnout may not be significant enough to trigger the cognitive processing that is associated with posttraumatic growth and reconstruction of an assumptive world. Posttraumatic growth is not related to the stress of the workplace but rather the exposure to a traumatic event and the shattering of someone's fundamental beliefs (Tedeschi & Calhoun, 1996). The lack of significance between posttraumatic growth and burnout within this sample could be representative of the fundamental difference between experiences of secondary traumatic stress and burnout as two separate constructs.

Burnout is a general experience that is not unique to the helping profession the results of this study provide further evidence that burnout is a construct that is applicable in any professional field. Burnout, although distressing, may not cause enough distress to prompt a fundamental challenging to assumptive worlds, thus it is not distressing enough to prompt rumination and change. This adds to the complex nature of posttraumatic growth and further investigation into the question of what enough distress to prompt growth is needed. This also can prompt further inquiry into the impact that engagement in the empathic relationship in the helping profession may have on experiences of posttraumatic growth as well as burnout.

Secondary traumatic stress is also unique as it is a result of engaging in an empathetic relationship that involves exposure to someone else's experiences of extreme trauma and/or adversity (Stamm, 2010). The low level of burnout reported by the sample does provide empirical evidence that lower levels of distress do not significantly relate to experiences of

posttraumatic growth and strengthens the construct of posttraumatic growth as a result of experiencing traumatic and distressing events.

The lack of relationship between burnout and posttraumatic growth within this sample could also be due to demographic variables such as income, training, and level of care participants were employed at, other variables that could contribute to lower levels of burnout could also be related to location and cultural contributions that could not be accounted for due to the anonymous nature of the research design. Further research is needed to explore how demographic and cultural differences could play a role in the development of burnout as well as how it relates to posttraumatic growth within the population of substance use helpers'. This adds further evidence that burnout alone is not enough to cause fundamental and transformative changes necessary for an individual to experience posttraumatic growth.

Research Question #3

The third research question in this study explored the relationship between secondary traumatic stress and posttraumatic growth. In order to experience posttraumatic growth, individuals need to experience an event that is significant enough to challenge their worldview and produce anxiety and distress that are difficult to manage (Tedeschi et. al., 1998). Substance use helpers are exposed to an endless sea of client traumas which present in varying degrees, from level of intensity to number of traumatic experiences, as well as types of traumatic experiences (interpersonal violence, sexual assault, abuse, etc). In addition to being exposed to client trauma's some substance use helpers' may themselves have first-hand experienced a traumatic event. This creates an environment that could be difficult for any helping professional to navigate and cope with the effects of working with individuals who have experienced trauma and could led to experiences of secondary traumatic stress among the helping population.

Secondary traumatic stress is the trauma that individuals experience as a result of being exposed to other's traumas (Stamm, 2009). Secondary traumatic stress can result in an individual experiencing fear, sleep difficulties, intrusive images, or avoiding reminders of their client's traumatic experiences (Stamm, 2010). Although research into vicarious experiences of posttraumatic growth are still outnumbered by research into vicarious trauma, a small, body of research has begun to explore the connection between these two constructs. Studies have illuminated the phenomena that occurs when individuals are exposed to the trauma of others. Research into this exposure to others trauma can lead to pathological effects however it can simultaneously lead to opportunities for growth. This is not to say that one would skip over the pathological effects of exposure to others trauma but rather that through the struggles associated with conceptualizing those traumas one has the opportunity to grow beyond their pre-exposure level of psychological functioning.

Associations between secondary traumatic stress and posttraumatic growth show positive relationships with higher levels of posttraumatic growth being associated with higher levels of secondary traumatic stress initially (Cosden, et. al., 2016; Kjellenberg, et. Al., 2014; Lahav, Solomon, & Levin, 2016). This indicates that psychological distress and growth are not mutually exclusive and instead psychological distress may be the impetus that advances change, both positively and negatively (Lahav et. al., 2016; Linely & Joseph, 2004; Tedeschi & Calhoun, 2004). Like other helping professionals who engage in an empathetic exchange, substance use helpers may experience posttraumatic growth as well as secondary traumatic as a result of exposure to clients who are struggling with variety of traumatic events.

The hypothesis for this research question stated that secondary traumatic stress, as measured by the secondary traumatic stress subscale of the ProQOL V, would not be predictive

of posttraumatic growth, as measured by the PTGI. This hypothesis was not supported by the results of the analysis and secondary traumatic stress was found to have a positive relationship with posttraumatic growth with this sample. This provides further evidence that secondary traumatic stress is a different construct than burnout and that it includes a disruption to an individual's fundamental beliefs, or schemas, about the world. This also provides further evidence that growth and distress are not exclusive, rather than can occurring simultaneously and the secondary traumatic stress can be a catalyst that prompts posttraumatic growth. This is a consistent finding with other populations of helping professionals and those who engage in an empathic relationship with an individual who has experienced trauma. For the substance use helpers' in this study those who experienced higher levels of secondary traumatic stress significantly experienced higher levels of posttraumatic growth. This suggests that like other populations of helping professionals, substance use helpers secondary traumatic stress and posttraumatic growth are independent constructs that not only co-exist, but also have a significant impact on one another. When substance use helpers' are exposed to a client's trauma, their basic assumptions about the world are challenged which can cause them to re-examine their life priorities, views, and the meaning of life and work and result in negative or positive changes. As substance use helpers' watch their clients struggle with their traumatic experiences the substance use helper's may experience increased levels of empathy and connection with others. The results of this question in this study add to the existing body of knowledge on correlations between secondary traumatic stress and posttraumatic growth and provide significant empirical evidence of a correlation between these two constructs within the population of substance use helping professionals.

Research Question #4

The fourth research question in this study explored the relationship between substance use helpers' personal characteristics, which included recovery status (abstinent, not in recovery, in recovery), trauma history, years of experience, level of care (LOC), gender, and educational level, with posttraumatic growth, as measured by the PTGI. Substance use helpers have unique personal characteristics that set them apart from other populations of helping professionals. The personal characteristics unique to substance use helpers are grounded in the literature and highlight the foundations of the field being based in helping professionals who they themselves had once been in treatment for a substance use disorder (Hagedorn, Culbreth, & Cashwell, 2012). This 'recovery status' so to speak, also sets them apart in regard to the fundamental qualifications to be a substance use helping professional as well as influences theoretical orientations and approaches to treatment (Hagedorn, et. Al., 2012; Henninger & Sung, 2012; White, 1998).

Previous research has examined personal characteristics of other populations of helping professionals that may relate to posttraumatic growth such as personal trauma history, relationship status, gender, and years of experience working in the field (Calhoun, Tedeschi, Cann, & Hanks, 2010; McGrath, 2011; Paredes & Pereira, 2017; Schultz, Tallman, & Altmaier, 2010; Starnino, 2016). The hypothesis for this research question stated that there would not be a relationship between substance use helpers' personal characteristics and posttraumatic growth as measured by the PTGI. The results of this study reject this hypothesis; however it is interesting to note that some personal characteristics that previous research indicated would be expected to be significant, such as personal trauma history, were not significant within this sample population. These findings are in alignment however with inconsistencies throughout the literature related to possible relationships between personal trauma experiences and vicarious posttraumatic growth (Cohen et al, 2013). This leads to the need for further research into

personal trauma experiences and vicarious posttraumatic growth. Future research should include trauma types (interpersonal, natural, relational, medical, etc) as they may relate to experiences of posttraumatic growth as well as vicarious posttraumatic growth.

The following variables (Gender, Education, Recovery Status, Years of Experience, Level of Care, Trauma History, Compassion Satisfaction, Secondary traumatic stress, Burnout, and Posttraumatic Growth) were entered into a Pearson product correlation statistical analysis in SPSS to examine potential significant relationships between all of the variables. Of the personal characteristics only gender, recovery, and education were shown to be significant with posttraumatic growth which led to their inclusion in the regression analysis. Of these characteristics accounted for 8.8% of the variance in PTGI scores and were statistically significant, $R^2=0.088$, $F(6,166)=2.59$, $p<0.05$ in predicting posttraumatic growth, as measured by the PTGI.

Although steps had been taken to increase the diversity of the sample such as limited inclusion criteria, the only inclusion criteria, that participants be at least 18 years old and have worked as a substance use helping professional for a minimum of 6-months, the sample population was still lacking in diversity. A majority of the sample worked in an outpatient setting (48.1%), held multiple licenses (33.9%), held a minimum of a Master's degree (66.1%), was female (65.5%), married (55.4%), and Caucasian (89.9%). This lack of diversity could have contributed to the research findings regarding personal characteristics and posttraumatic growth among substance use helping professionals.

In addition to the limited diversity within the sample population 'recovery status' data was collected via one question on the demographic questionnaire which asked participants to choose which they identify most with in terms of their own personal recovery status. The options

they were given to choose from included “I identify as being in recovery from a substance use disorder”, “I identify as abstinent from drugs and/or alcohol”, or “I do not identify as having a substance use disorder”. These options were later transformed to represent those “in recovery”, those “abstinent”, and those “not in recovery”. Further research into measuring an individual’s status as well as developmental placement along a recovery spectrum are needed to better assess an individual’s status in regard to substance use disorder.

Overall compassion satisfaction, burnout, and secondary traumatic stress was significantly predictive of posttraumatic growth with this sample of substance use helpers and accounted for 17% of to the total variance. In combination with the personal characteristics the model accounted for 25.8% of the total variance and was shown to be statistically significant at the $p < 0.05$ level. These results provide empirical evidence to support substance use helpers’ experiences of posttraumatic growth. This also provides further evidence that engagement in an empathetic helping relationship may result in both positive (posttraumatic growth, compassion satisfaction), as well as negative (secondary traumatic stress, burnout) consequences for the helping professional. Substance use helping professionals can experience both the positive and negative consequences of engagement in a therapeutic relationship. Further research is needed to elucidate factors that contribute to positive consequences of working with this difficult population of clients.

Limitations

This study had several limitations that were specific to the method and sample of the study. The results were not generalizable because of the limitations to the sample; for example, the limited diversity within the demographic information of the sample population, in addition geographical data was not obtained therefore cultural influences, such as urban vs rural, cannot

be accounted for. Level of care that substance use helpers worked in was collected however not all groups were equal and therefore could not accurately represent different levels of intensity of services and exposure to client traumas. A large majority of the sample was employed at the outpatient setting which indicates that their clients may have experienced less dysfunction than those who were employed at a higher level of care such as residential or in dually diagnosed treatment programs. The ethnicity of the sample was not representative of all substance use helping professionals as it consisted of a majority Caucasian subjects and lacked overall diversity.

Another limitation to this study was the sample selection was non-random, voluntary, and self-selected. This method of selection precludes any claims to sample representativeness or generalizability. The study population was smaller than was hoped for at the onset of the study. Although the sample size met G*Power analysis which stated that a minimum of 163 participants were needed for the study, it was hoped that a larger sample would be collected in order to increase diversity among the sample as well as generalizability of the results. Numerous factors influenced the sample size in that the researcher used an online survey design that could have caused some technical difficulties. These technical difficulties could have included problems with access for individuals who may not be familiar with online survey software or have limited access to a computer with internet connections. Participation in counselor research may not have been a part of different facilities culture, and some facilities declined requests for participation citing that they only promote research done within their organization. There were also no questions presented to participants designed to collect the geographic location of participants which could have skewed the interpretation of questions and responses. Participants geographic location could have provided further insight into how location can influence substance use

helping professionals demographic information, type of services provided, level of care employed in, level of supervision, education, ethnicity, and cultural influence on experiences of both positive and negative consequences of engaging in a therapeutic helping relationship. Lastly, some substance use helpers' may not be familiar with research and may have been resistant to participating in the study. Limited understanding of the importance of participation within research could have led to some potential participants resistance in participation or lack of commitment in completing the questionnaires.

The benefits and burdens of study participation may have limited the sample size as well as focus of participants. There was a total of three surveys to complete with an estimated time commitment of approximately 45 minutes. It is possible the length of time involved in the study participation led to a few limitations including limited sample size, incomplete questionnaires and participation drop out. The surveys used in this study were self-report measures which have a variety of limitations associated with their use, one of which is that people may misrepresent their views and competence. Lastly, I may have also been a limitation of this study through my own presumptions and biases in interpreting the data (Patton, 2002). I have prior experience working in multiple different levels of care within the substance use disorder field and have been working as a substance use helping professional for roughly 10 years. I bring my own notions of the work and its effects that may have influenced the research. I attempted to mitigate these issues through the use of consultation and supervision.

Implications for the Helping Profession

Substance use treatment continues to evolve and present unique challenges that those who work in the field must rise up to meet. With the opiate epidemic and need for quality substance use treatment at historically high levels, substance use helpers are faced with new and

ever-expanding challenges; however, with any challenge there is an opportunity for reward. Substance use helpers are in a unique position to effect meaningful change not just for their clients but also for themselves. Helping professionals are often educated about the negative consequences of working with individuals diagnosed with substance use disorder including the role of trauma and working within highly stressful environments. Many are warned of the dangers of phenomena's such as burnout, secondary traumatic stress, and vicarious trauma however few are taught of how these experiences may be a normal reaction to the secondary exposure of their client's life experiences. Not only can education surrounding the negative consequences be further illuminated but education regarding the positive consequences of this work may also be outlined within curriculum and continuing education plans

Shifting focus onto the benefits of working with a challenging population allows substance use helpers to increase abilities that can help in not just sustaining well-being but thriving both personally and professionally. This creates new paths for substance use helpers' to continue to learn and grow within the difficulties of engaging in an empathic, therapeutic relationship with this population of clients. Lack of meaningful investigation into support and benefits of substance use helpers only drives individuals out of the field, increases turnover, diminishes productivity, disempowers and defeats the warriors battling the substance use epidemic that is "sweeping the country" (Chang, 2018).

This study has significant implications for all aspects of the field of substance use counseling, including counselor education, clinical applications, training, and supervision. The results of this study indicate that compassion satisfaction, secondary traumatic stress, and educational level are statistically significant predictors of posttraumatic growth among substance use helpers' who participated in this study. These results have important implications for the

profession. Education and clinical training are two areas of utmost importance in providing and maintaining an effective population of substance use helpers'. Organizations, educational institutions, and clinical supervisors have a responsibility to ensure that their students and/or staff are well educated in how working with individuals diagnosed with substance use disorders may affect helping professionals.

There needs to be minimum standards of education practices which outline standardized curriculum and training to provide clinical services to individuals diagnosed with substance use disorders. Minimum standards of education and training should include educational programming on both the positive and negative consequences of engaging in an empathetic, therapeutic relationship, as well as working with individuals diagnosed with substance use disorders. Educational programming should be provided on all levels including at the undergraduate, graduate, and continuing education levels of practice. In addition to clinical training for substance use helpers', specialized training and education may be provided to clinical supervisors of substance use helpers. An understanding that experiences of secondary traumatic stress is a normal part of experiencing posttraumatic growth would raise awareness of the construct. In addition, knowledge of the role secondary traumatic stress plays in the development of posttraumatic growth may be helpful for substance use helpers to understand the continuum of normal reactions to working with difficult populations such as those diagnosed with substance use disorders.

This specialized training for clinical supervisors should focus on the unique challenges that this population of helping professions are exposed to as well as methods to bolster positive consequences of engaging in a therapeutic relationship such as posttraumatic growth and compassion satisfaction. In addition, specialized training and continued education for

supervisors of substance use helpers' should focus on factors that both promote positive consequences of engaging in a therapeutic relationship but also put individuals at risk of experiencing negative consequences. This can allow for more individualized supervision plans and goals that clinical supervisors can use with their supervisee's.

Additionally, the results from this study can provide knowledge on characteristics and domains associated with the benefits of working with individuals diagnosed with substance use disorder. Organizations would also benefit from the results of this study as it provides insight into both the positive and negative consequences of working within the substance use helping field. Organizations should provide opportunities for employees who provide clinical services for further training and education surrounding posttraumatic growth and the impact of working within the substance use helping field. Organizations can also gain knowledge on unique challenges that this population of helping professionals face and reorganize standards of educational qualifications for clinical service providers. In addition, organizations should develop incentive opportunities for their employees who offer clinical services that promote positive consequences and provide buffers to negative consequences of working as a substance use helper. Increased training opportunities, self-care opportunities, mandatory vacation days, some form of reimbursement for continuing education, and free specialized trainings on unique factors associated with working as a substance use helping professional would benefit employees as well as create protective factors to reduce turnover within an organization.

The results of this study provide further insight into the construct of posttraumatic growth, compassion satisfaction, secondary traumatic stress, and burnout and their relationship with substance use helping professionals. The study also provides recommendations for clinical practice at all levels including education, clinical application, supervision, organizational, and

continuing education. The results of this study also indicate that substance use helping professionals, like other populations of helping professionals, do experience posttraumatic growth as a result of engaging in an empathetic relationship with their clients. This study also provides empirical evidence to support posttraumatic growth as a separate construct from others as well as provides new insights into how this construct presents with the substance use helping population.

Implications for Future Research

A number of areas for further research arose from this study. The results of this study identified personal characteristics that could lead to increases in positive consequences of working within the substance use disorder field. It would be beneficial to delve into specific characteristics and determine if they do indeed contribute to experiences of positive consequences for substance use helping professionals (compassion satisfaction, posttraumatic growth). In addition, it would be beneficial to examine possible relationships with personal characteristics, positive consequences and length of employment and job satisfaction. An awareness of what characteristics increase the likelihood that staff will remain in the field could prove to be extremely helpful to the retention of quality staff within the field of substance use helpers which has been noted as having a very high turnover rate. Other personal characteristics to be further explored that are specific to substance use helpers are personal substance use disorder history, educational level, and level of care they are employed in (outpatient vs inpatient, long-term vs short-term, etc). Research into these characteristics can further shed light on the experience of posttraumatic growth and professional quality of life and associates with personal characteristics.

Personal characteristics should also be further explored in regard to possible relationships with different factors associated with both positive and negative consequences of substance use helping professionals. Research into personal characteristics associated with different factors associated with posttraumatic growth would be beneficial in the development of individualized training and supervision of this helping population. This study only analyzed overall growth in regard to posttraumatic growth, future studies that narrow the scope to how personal characteristics could relate to different factors of posttraumatic growth (relating to others, new possibilities, personal strength, spiritual change, and appreciation for life) would further illuminate contributors to the overall construct of posttraumatic growth as well as how this population of helping professional may differ from others.

Exploration of environmental characteristics within this population of helping professionals would also be beneficial. Increasing research into the professional environment of substance use helpers could lead to increases in satisfaction with work and promote growth among substance use helpers as well as identification of risks factors for pathogenic responses such as secondary traumatic stress and burnout. Future research should narrow in on quantifying substance use helpers' experiences with supervision as well as operationalize and measure differences between those who experience high quality clinical supervision and those who experience low quality clinical supervision. Clinical supervisor theoretical orientation may also play a role in the relationship between experiences with supervision and experiences of posttraumatic growth among this helping population. Future research focused on supervision factors that may impact experiences of posttraumatic growth among substance use helping professionals would be beneficial in both application and education. Further research into the area of supervision is needed throughout the helping professions however qualifications and

personal characteristics that are unique to the field and hierarchy of substance use treatment could prove to have factors that can contribute to retention, quality of clinical staff, as well as substance use helpers' experiences of positive consequences such as posttraumatic growth as a result of their work.

Other factors recommended for future research include organizational theoretical orientation to substance use treatment, location (rural vs urban), type of treatment provided (abstinence only, medication assisted, 12-step, faith based, etc), private vs public funded, theoretical orientation of the substance use helping professional would also be beneficial for future research in understanding the construct of posttraumatic growth with this population of helping professionals. Not only would this provide greater insight into the construct of posttraumatic growth, but it would also provide greater understanding of factors associated with both positive and negative consequences for this population of helping professionals. Furthering research into the exploration of both positive consequences, such as posttraumatic growth, and negative consequences of working with substance use disorder can only serve to enhance the field.

Conclusions

Posttraumatic growth among helping professionals has seen an increase in the professional literature over the past several years. As a result, research into factors that contribute to positive consequences, such as posttraumatic growth, of engaging in a therapeutic relationship have begun to be further explored. These positive consequences have also begun to be explored regarding how they may be experienced by different populations of helping professionals. Substance use helpers historically bring unique backgrounds and face unique challenges compared to other populations of helping professionals (Perkins & Sprang, 2013;

White, 1998). Despite these unique challenges, it would appear substance use helpers report significant experiences of posttraumatic growth as it relates to compassion satisfaction, secondary traumatic stress, and burnout. In addition, personal characteristics of substance use helpers also contribute to this population of helping professional's experiences of posttraumatic growth.

There is still much to be learned about posttraumatic growth and the positive consequences of engaging in a therapeutic relationship with in the substance use helper population. The next steps for this research are to replicate this study at multiple different levels of care (Outpatient, partial hospitalization, residential, long-term, short-term), locations (rural vs urban), and theoretical orientations/approaches (abstinent only, 12-step, medication assisted, faith based) to substance use treatment providers. Other relationships such as substance use helpers' posttraumatic growth and client experiences of posttraumatic growth, could provide additional highlights into both clinical outcomes and substance helper practice and retention.

Academic research is also needed to identify specific educational outcomes related to posttraumatic growth, for example will substance use helpers trained on posttraumatic growth report higher scores than those who have not been trained, will those trained on posttraumatic growth have better satisfaction and retention as opposed to helpers who have not received any training. Longitudinal studies looking at posttraumatic growth over time could also be beneficial especially if paired with personal characteristics, for example do individuals who are themselves in recovery experience higher rates of posttraumatic growth over time when compared to those who do not identify as being in recovery. Research focusing on additional demographic characteristics could also increase professional knowledge base around posttraumatic growth and should be considered.

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APPENDIX A

CONSENT TO PARTICIPATE IN STUDY



DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: An Exploratory Investigation into The Relationship Between Substance Use Helpers Professional Quality of Life and Posttraumatic Growth

INVESTIGATOR:

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SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in the School of Education Counselor Education and Supervision Program at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate substance use helpers' experiences as a result of their work with clients diagnosed with a substance use disorder. This research is in partial fulfillment of the requirements for the doctoral degree in the School of Education at Duquesne University and is being conducted by a doctoral candidate in the Counselor Education and Supervision program at Duquesne University. You are being invited to participant in this research because you are currently providing direct clinical services to individuals diagnosed with a substance use disorder. You are being asked to

participate in completion of three online surveys that will take approximately 30 minutes to complete.

In order to qualify for participation, you must be:

-18 years old or older

-Have a minimum of six months' of experience providing direct clinical services to individuals diagnosed with a substance use disorder

PARTICIPANT PROCEDURES: To participate in this study, you will be asked to: Complete three online surveys which will take approximately 30 minutes to complete. The online surveys will include a 13-item demographic questionnaire, the Professional Quality of Life Scale V which is 30-items, and the Posttraumatic Growth Inventory which is a 21-item questionnaire. You will only need to complete these questionnaires once and will be notified at the completion of all questionnaires. Following completion of all questionnaires you will be asked if you would like to be entered in a chance to win one of two \$50.00 Amazon gift cards. Completion of all three questionnaires will take approximately 30 minutes. These are the only requests that will be made of you.

RISKS AND BENEFITS: There are minimal risks associated with participation in this study, no greater than those encountered in everyday life. A benefit of participation includes increasing understanding of potential relationships among substance use helpers experiences associated with working with individuals diagnosed with substance use disorder. Describe all risks and benefits for participating in this study.

COMPENSATION: Compensation will be provided in the chance to be entered into a lottery style drawing to win a \$50.00 Amazon gift card. Participants must complete all three online survey questionnaires in order to qualify for the chance to be entered into the lottery-style drawing. The lottery-style drawing will be conducted at the completion of data collection. Participation in this project will require no monetary cost to you.

CONFIDENTIALITY: All responses in this study are anonymous as they are being provided through an online forum. Your name will never appear on any survey or research instruments. All electronic forms and study materials will be kept secure. Your response(s) will only appear in statistical data summaries. Any study materials will be maintained for three years after the completion of the research and then destroyed.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time without suffering any negative consequences.

SUMMARY OF RESULTS:

A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT:

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any

time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may contact Denise Haggerty or the advisor of the study Debra Hyatt-Burkhart. I have any questions regarding protection of human subject issues, I may contact Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board.

Duquesne University's Institutional Review Board has approved/verified this research study

If you proceed to the next page, it indicates that you have agreed to consent to your participation in the research study.

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

1. What is your age?
2. Please select the gender you identify with:
 - a. Male
 - b. Female
 - c. Nonconforming
3. Ethnicity
 - a. African American
 - b. American Indian or Alaska Native
 - c. Asian
 - d. Hispanic or Latino
 - e. Other Pacific Islander
 - f. Caucasian
4. Relationship status
 - a. Single
 - b. Married
 - c. Long-term committed relationship
 - d. Divorced
 - e. Widowed
 - f. Other
5. What is your highest completed level of education:
 - a. High School diploma/GED
 - b. Bachelor's degree
 - c. Master's degree
 - d. PhD
6. Please choose the option that best describes you in terms of licensure or Certification you may possess:
 - a. Certified Addiction Counselor
 - b. National Certified Counselor
 - c. Licensed Professional Counselor
 - d. I hold multiple licensure and certification
 - e. I do not hold any Licensure or Certification
7. How many years of experience do you have providing direct services to individuals diagnosed with substance use disorders:
8. Choose the option that best describes the quality of the clinical supervision you receive:

- a. Excellent
 - b. Very Good
 - c. Good
 - d. Fair
 - e. Poor
 - f. Very Poor
9. Please choose the option that best describes the importance of Religion or Spirituality in your life:
- a. Extremely important
 - b. Very Important
 - c. Moderately Important
 - d. Slightly Important
 - e. Not at all important
10. Please select the recovery status you most identify with:
- a. I am abstinent from Alcohol and Other Drugs
 - b. I am in recovery from a substance use disorder
 - c. I have never had a substance use disorder
11. Select the level of care that you work in:
- a. Long-term residential
 - b. Short-term residential
 - c. Outpatient
 - d. Private Practice
12. Do you have any personal history of trauma:
- a. Yes
 - b. No

APPENDIX C

Professional Quality of Life Scale V (Stamm, 2010).

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never

2=Rarely

3=Sometimes

4=Often

5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I help.
3. I get satisfaction from being able to help people.
4. I feel connected to others.

5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I help.
7. I find it difficult to separate my personal life from my life as a helper.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
9. I think that I might have been affected by the traumatic stress of those I help.
10. I feel trapped by my job as a helper.
11. Because of my helping, I have felt "on edge" about various things.
12. I like my work as a helper.
13. I feel depressed because of the traumatic experiences of the people I help.
14. I feel as though I am experiencing the trauma of someone I have helped.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with helping techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a helper.
20. I have happy thoughts and feelings about those I help and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help
24. I am proud of what I can do to help.
25. As a result of my helping, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a helper.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

APPENDIX D

Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996)

This measure was adapted with the permission from the authors to reflect the impact of an individual's work as opposed to their direct personal experiences. All appropriate permissions were granted prior to the adaptation and use of the measure.

Indicate for each of the statements below the degree to which this change occurred in your life as a result of your work with individuals diagnosed with substance use disorders, using the following scale.

0= I did not experience this change as a result of my work.

1= I experienced this change to a very small degree as a result of my work.

2= I experienced this change to a small degree as a result of my work.

3= I experienced this change to a moderate degree as a result of my work.

4= I experienced this change to a great degree as a result of my work.

5= I experienced this change to a very great degree as a result of my work.

Questions:

1. I changed my priorities about what is important in life.

2. I have a greater appreciation for the value of my own life.

3. I developed new interests.
4. I have a greater feeling of self-reliance.
5. I have a better understanding of spiritual matters.
6. I more clearly see that I can count on people in times of trouble.
7. I established a new path for my life.
8. I have a greater sense of closeness with others.
9. I am more willing to express my emotions.
10. I know better that I can handle difficulties.
11. I am able to do better things with my life.
12. I am better able to accept the way things work out.
13. I can better appreciate each day.
14. New opportunities are available which wouldn't have been otherwise.
15. I have more compassion for others.
16. I put more effort into my relationships.
17. I am more likely to try to change things which need changing.
18. I have a stronger religious faith.
19. I discovered that I'm stronger than I thought I was.
20. I learned a great deal about how wonderful people are.
21. I better accept needing others.

